FEBRUARY 2026 | VOLUME 37 | ISSUE 1

# THERAPY TODAY

bacp | counselling changes lives


## Therapy on demand

### THE GROWING COMMODITISATION OF OUR PROFESSION

THERAPY TODAY
FEBRUARY 2026 | VOLUME 37 | ISSUE 1

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## Trustpilot

### Enriching training

The training was fantastic from start to finish. Thorough, insightful, enriching and fun! The tutors are so supportive in every way. I have grown with their guidance and must say it is one of my best training course experiences. They adapt to all styles of learning, it's extremely inclusive, and it's managed professionally from start to finish.

*– Beverley Hanley, Dip.Couns, CCS Counsellor and Clinical Supervisor*

### This is a fabulous training

Very well structured with a mixture of self-study and live elements. With warm, knowledgeable and supportive tutors and great support. I would highly recommend it.

*– Ellie Finch, MA, MBACP (Accred)*

### Can't recommend enough!

I recently completed all my modules for the clinical supervision qualification with Counselling Tutor, and honestly cannot recommend them enough!
Clearly set out and well delivered with a mix of both theory and practical which I really enjoyed.

*– Claire Kennaby, MSc, MBACP*


# Contents

26 *'Traditional therapist directories now have to compete with the marketing budgets of the large subscription-based online therapy platforms'*

**Sally Brown** ('One-click culture', pages 26-31)







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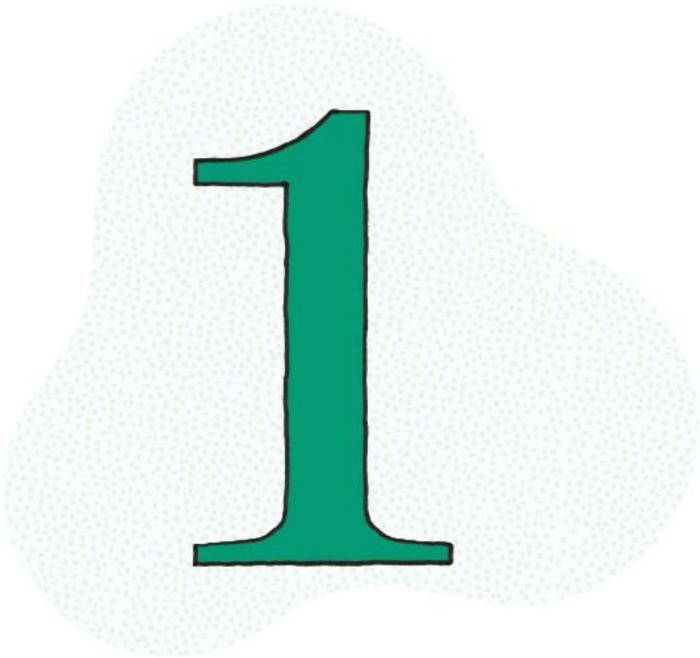


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* Based on 1 client attending 5 sessions each priced at £60. ** Offer price of £49 one-time setup (excl. VAT), then £20 monthly fee (incl. VAT) after 30 days. Offer valid for February 2026.

# THERAPY TODAY

Finances are a focus for many of us at this time of year. With the HMRC bill deadline just gone, insurance renewals due and the loom of the new tax year round the corner, the business side of our profession comes acutely into view. It's perhaps more the case than ever this year as Making Tax Digital starts to roll in, leaving many of us feeling exposed, especially if we're not feeling tax savvy. While conversations about income are increasingly prevalent, ripples of taboo around it still exist. How financially viable is a therapy career today, and is there enough work to go round? Whichever choices we seem to make – to focus solely on client work or diversify into a portfolio career – we're perennially facing the same pay-off: do we take on more work to make ends meet and risk burnout, or prioritise our self-care and take the financial hit?

Mental health campaigns have also shaped public discourse and client expectations of therapy. I have certainly noticed changes in how clients seek support. The extent to which therapy is pitched publicly as a 'customer service' is growing, and social media has influenced the way in which we can feel pushed to market ourselves. In this month's 'Big issue' on the growing commoditisation of our profession (page 26), Sally Brown really gets to grips with this changing landscape.

*'Despite our skillsets becoming commoditised in the current economy, we are still people behind our marketing'*

Perhaps linked to this theme is Julia Bueno's 'Viewpoint' piece on the rise of therapy speak (page 70), looking at how our professional language has seeped into public parlance. What are the consequences for us?

Elsewhere within these pages are other commonalities we can face as practitioners, such as working through our own self-esteem while supporting clients (page 52), sharing our own vulnerability with them as we go through major life changes (page 74) and how we use empathy (page 56).

Ultimately, despite our skillsets becoming commoditised in the current economy, we are still people behind our marketing. Behind our client-facing personas we are only human, and my hope is that any fellow practitioners struggling with their working life remember they are not alone.

**Katerina Georgiou MBACP (Snr Accred)**
Editor

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# Noticeboard

Our monthly digest of news, updates and events



**57%**

of therapists have seen an increase in men coming to therapy*

*BACP.CO.UK/ABOUT-US/ABOUT-BACP/BACP-MINDOMETER-2025

NEWS REPORT

MEUNIERD/SHUTTERSTOCK

## MP report on mental health services reflects our calls for improvement

In a new House of Commons Committee report published on 2 December 2025, MPs have highlighted a need for round-the-clock neighbourhood mental health centres in every community and more sustainable funding for third sector organisations. Its recommendations reflect two of our policy calls, which we highlighted in recent consultation responses to Government.

Matthew Smith-Lilley, our Policy and Engagement Lead (Mental Health), said: 'The Committee's recommendations are common-sense calls that would have a positive impact on counselling provision – and would help more people in need access vital therapeutic support.

'They've highlighted some of the key points we've been making to policy makers and commissioners over the past few years.

'We've seen first-hand how the Neighbourhood Mental Health Centres are fantastic examples of innovative practice that are seeking to bring care closer to people and communities. It's crucial this pilot programme has sufficient funding, and it's vital that we're able to learn the lessons of this mode of delivery.

'Third sector mental health services are facing challenges, complexities and uncertainties in their funding, impacting their ability to deliver life-changing therapy. They must have greater certainty and stability in their funding by receiving multi-year service contracts.

'The Government and NHS England must act on this report to ensure improved access to therapy for those in need.'

Read the full health and committee report and recommendations at **publications.parliament.uk/pa/cm5901/cmselect/cmhealth/566/report.html**

BACP UPDATE

PIXEL-SHOT/SHUTTERSTOCK

## Your Voice, Your BACP

We're proud to tell you about Your Voice, Your BACP – a programme designed to put our members at the heart of everything we do.

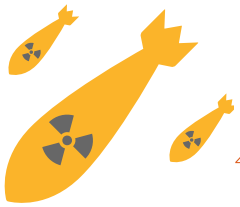
The past few years have brought a lot of change and, with that, some significant challenges. We recognise that we haven't always got everything right, but we're committed to improving the way we work with you to rebuild trust and make sure that every member feels valued, heard and involved.

We know that there is a vast amount of expertise among our membership, and there is a lot more we can do to enable our members to engage with, inspire and shape how we support the counselling and psychotherapy profession.

Throughout 2026 we'll be providing multiple opportunities to co-create a better approach to member engagement so that you can benefit from each other's expertise, help shape the future of BACP and create positive long-term change for our profession.

We'll share more ways for you to get involved soon. Write to us at **yourvoice@bacp.co.uk**

# Noticeboard



**4 in 5** adults say they feel anxious about war and conflict*

## FROM THE EXECUTIVE DIRECTOR

**Ben Kay,**
**Executive Director**

The need for mental health support has never been greater. Demand for therapy far exceeds supply, and in that gap new players are flooding the market offering convenience and low-cost access. These services meet a need but risk reducing therapy to a quick transaction, stripping away the trust, ethics and human connection that make it effective.

We cannot stop market forces. Where opportunity exists, new entrants will appear. But together we can and must be clear about our difference to these services. Our profession stands for qualified, ethical and relational care. That is our strength. Advocacy means championing what we do best, not tearing down alternatives. When we lead with clarity and confidence we protect the public and reinforce trust in our work.

Consumerisation will reshape expectations. People increasingly want therapy that fits their lives: fast, affordable and accessible. We should acknowledge this reality but never compromise on what makes therapy transformative: the depth of human relationship, professional standards and ethical practice.

Our responsibility is twofold: to educate the public about what safe, effective therapy looks like and to innovate responsibly to meet changing needs without losing our core values. We need to be considering what next generation therapy feels like. This means embracing technology where it enhances care but resisting any trend that reduces therapy to a commodity.

The future of therapy must not be dictated by convenience alone; it should be guided by principles that put people first. This is our moment to lead, not by resisting change but by showing why what we offer matters more than ever.

*MIND.ORG.UK/ABOUT-US/OUR-POLICY-WORK/THE-BIG-MENTAL-HEALTH-REPORT/#FINDINGS

BACP NEWS

## Mindometer brings therapists' insights to national media

Our latest Mindometer survey, completed by almost 3,000 members, sparked national coverage on *Channel 5 News* and in *The Times*, *The Daily Mail* and *Metro*.

*Channel 5 News* highlighted our findings on AI therapy, including that 28% of therapists have seen clients receive 'unhelpful advice' from AI, and that more children are turning to it for support. Debbie Keenan explained the risks and why speaking to a qualified professional remains vital. *The Times* also explored the concerns around children seeking mental health guidance from AI, featuring further insights from Debbie.

*The Daily Mail* reported on the rise in family-related issues, with almost half of therapists noting an increase over the past year, with comments from Georgina Sturmer and Bhavna Raithatha. *Metro* also covered the survey, focusing on the rise of people seeking support for bullying at work, including insights from Pallvi Dave and Jodie McCormack.

Find out more at **bacp.co.uk/about-us/about-bacp/bacp-mindometer-2025**

MARINA SANTIAGA/SHUTTERSTOCK

## DIARY DATES

bacp.co.uk/events

**11 FEBRUARY**
ONLINE

### Working With Artificial Intelligence (AI)

Does artificial intelligence mean artificial therapy?


IMAGEFLOW/SHUTTERSTOCK

**25 FEBRUARY**
WALES

### Making Connections

Free CPD and networking event for members

LISYL/SHUTTERSTOCK

ANDREY_POPOV/SHUTTERSTOCK

BACP EVENTS

## Working with artificial intelligence

Artificial intelligence (AI) is already reshaping everyday life. From search engines to virtual assistants, entire industries are changing and responding, often with fear.

Join us on Wednesday 11 February 2026 for our event 'Working with Artificial Intelligence (AI): does artificial intelligence mean artificial therapy?', which will explore what it means to be AI-ready in clinical practice, from ethical frameworks to practical applications.

We'll cover the different types of AI, how AI might support or challenge therapeutic work and whether AI could ever truly provide counselling as we see it.

With expert input, the event will give attendees a space to examine the potential and risks of AI in therapy, and how to engage with this rapidly evolving technology responsibly.

Join us online or catch up with the on-demand service that will be available for three months after the event.

To book, visit **bacp.co.uk/events/www110226-working-with-artificial-intelligence-ai-does-artificial-intelligence-mean-artificial-therapy**

**36%** of therapists described demand at their practice as overcapacity*

*BACP.CO.UK/ABOUT-US/ABOUT-BACP/BACP-MINDOMETER-2025

## Spreading the word

### Promoting our members and our profession through the media

In *Mashable* **Jonathan Eddie** offered advice on coping with relationship break-ups. • **Kemi Omijeh** discussed feeling positive and loving your Afro in *Cosmopolitan*. • In *The Daily Telegraph*, **Andrew Harvey** delved into unhealthy drinking habits, and **Sarai Monk** highlighted the tell-tale signs of people-pleasing. • **Charlotte Fox Weber** explored how social media is changing dating and flirting in *Metro*. • **Brieanne Doyle** spoke to PA Media about avoiding social isolation after retiring – this was also reported by *The Independent*, MSN, AOL, *The Irish News* and Yahoo! • **Bhavna Raithatha** and **Alec Williams** explored a sense of a foreshortened future and managing an adult child's sexuality in *HuffPost*, respectively. • **Ayo Adesioye**, **Anjula Mutanda** and **LJ Jones** spoke to Yahoo! about the signs you're falling out of love, how to tell if someone has a crush on you and whether a partner may be too attached to their mother, respectively. • **Katerina Georgiou** examined the nuances of non-monogamous relationships in *The Guardian*. • **Vasa Toxavidi** and **Madeleine Kingsley** also spoke to Yahoo! discussing what break-ups can teach us and how to spot when a relationship is heading for trouble, respectively. • **Paula Hall** spoke to PA Media about the signs of porn addiction – her comments also featured in *The Independent*, AOL and Yahoo! • **Debbie Keenan** appeared on *Channel 5 News* discussing the risks of AI-generated guidance in their exclusive report on findings from our annual Mindometer survey. • **Georgina Sturmer**, **Bhavna Raithatha** and **Jodie McCormack** also discussed our Mindometer survey that found almost half of therapists have reported an increase in family-related issues over the past year, in *The Daily Mail* and *Metro*.


BHAVNA RAITHATHA


VASA TOXAVIDI


AYO ADESIOYE


JODIE MCCORMACK

**7 MARCH**
**LONDON/ONLINE**

### Children, Young People and Families Conference

Likes, lives & layers: unpacking the digital impact on young minds

PICS FIVE/SHUTTERSTOCK

**18 MARCH**
**SHEFFIELD**

### Making Connections

Free CPD and networking event for members

ALEXEY FEDORENKO/SHUTTERSTOCK

# Accredited Counselling and Psychotherapy Courses in Sussex and Online

Elevate your practice with The Link Centre's exceptional Supervision Diploma, CPD and psychotherapy courses, guided by our team of highly-experienced tutors.

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  We offer both in-person and online accredited 30-hour Certificate in Counselling Skills courses, for those at the beginning phase of their counselling practice.
- **DIPLOMA IN SUPERVISION (ONLINE)**
  **16 May – 8 Nov 2026, six weekends, Sat and Sun, 9.30am–4.15pm**
  For practitioners wishing to enhance their portfolio by adding supervision, enabling them to work with students and qualified professionals within their own modality and across others.
- **ADVANCED DIPLOMA IN INTEGRATIVE PSYCHOTHERAPY (LEVEL 7 EQUIVALENT)**
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- **CERTIFICATE IN APPLIED TRANSACTIONAL ANALYSIS (ONLINE)**
  **21 Oct 2026 – 14 Apr 2027, 24 sessions, Wed, 6.30–9pm**
  Expand your TA knowledge and integrate it confidently into your clinical work.

## UPCOMING CPD COURSES (ONLINE):

- **HOW TO WORK RELATIONALLY WITH LOSS, GRIEF AND THE AFTERMATH OF SUICIDE**
  – with Adena Franses, CTA, TSTA
  **4 Mar – 13 May 2026, fortnightly Wed, 6–9pm**
  Explore the complexities of working therapeutically and relationally with clients experiencing loss, grief, bereavement and suicide.
- **PROJECTIVE IDENTIFICATION IN CLINICAL PRACTICE: A SIX-STAGE RELATIONAL METHODOLOGY**
  – with Alistair Berlin, PTSTA
  **Sat 23 May 2026, 9.30am–4.30pm**
  Explore projective identification as a two-person relational process and provides a practical six-stage framework for working with it in clinical practice.
- **LAUNCHING SOON:**
  - Certificate in Working with Couples and Relationships
  - Certificate in Delivering Group Therapy

## FREE ONLINE TALKS:

**OPEN EVENINGS**
- 9 Mar or 11 May, 6–7pm

Meet the team, ask questions and explore your training options.

**HOW TO BECOME A SUPERVISOR**
- 9 Feb 2026, 6.30–7.30pm

Find out how to transition from being a counsellor to supervisor.

*We are based in the AgriFood Centre, Plumpton College, Wales Lane Farm, East Sussex, BN7 3AE*

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**1/5** of therapists report that young people are receiving harmful mental health advice from ChatGPT and AI*

*BACP.CO.UK/ABOUT-US/ABOUT-BACP/BACP-MINDOMETER-2025

YOUR QUESTIONS ANSWERED

# Networking

**Rebecca Stew,** BACP Communities Lead

**How do I set up a network meeting?** We hold a small budget to help set new meetings up and can cover room rental fees for in-person meetings. We would love to have network meetings across all four nations and we can also help locate your closest meeting. To arrange a chat, contact us on **communities@bacp.co.uk**

**What is Communities of Practice?** This is a BACP members-only discussion forum with more than 30 communities covering a range of topics across therapy. You must be logged into your BACP membership to access the forum. Find out more at **bacp.co.uk/events-and-resources/bacp-events/communities-of-practice**

**How do I join a division and what are the benefits?** Our divisions are networks of groups with special areas of interest. We have seven divisions: Children, Young People and Families; Coaching; Healthcare; Private Practice; Spirituality; Universities and Colleges; and Workplace.

Each division is managed by an executive committee of volunteers that run their own meetings and formulate workstreams in line with BACP objectives. Divisional membership is of value to anyone working within these specific fields of counselling. Each division publishes a quarterly journal and provides member-only benefits, including specialist resources and events. Find out more at **bacp.co.uk/bacp-divisions** or email us at **divisions@bacp.co.uk**.

BACP EVENTS

## Children, Young People and Families (CYPF) Conference 2026

From the rise of controversial online figures to the impact of political rhetoric and algorithm-driven content, practitioners are increasingly called to navigate digital landscapes and cultural tensions in their work.

Taking place in London and online on Saturday 7 March 2026, the CYPF Conference will bring together leading voices in child and adolescent mental health to explore the complex social influences shaping the lives of young people today.

Join us online or in person for keynote presentations, panel discussions and practical workshops that will offer insight into how these forces affect identity, wellbeing and relationships, and how social, digital and cultural influences shape the mental health, identity development and relational dynamics of children, young people and families.

It will examine:

- the psychological impact of social media platforms, algorithms and influencer culture
- the rise of polarising figures and their influence on gender identity, masculinity and peer dynamics
- how political discourse and societal narratives affect young people's sense of belonging, safety and agency
- strategies for CYPF practitioners to engage critically and compassionately.

For more, visit **bacp.co.uk/events**

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**14-16 MAY LONDON**

**Research Conference and pre-conference**

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**10 OCTOBER LONDON**

**Member event**

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**Mark L.** — *Private Practice Owner*

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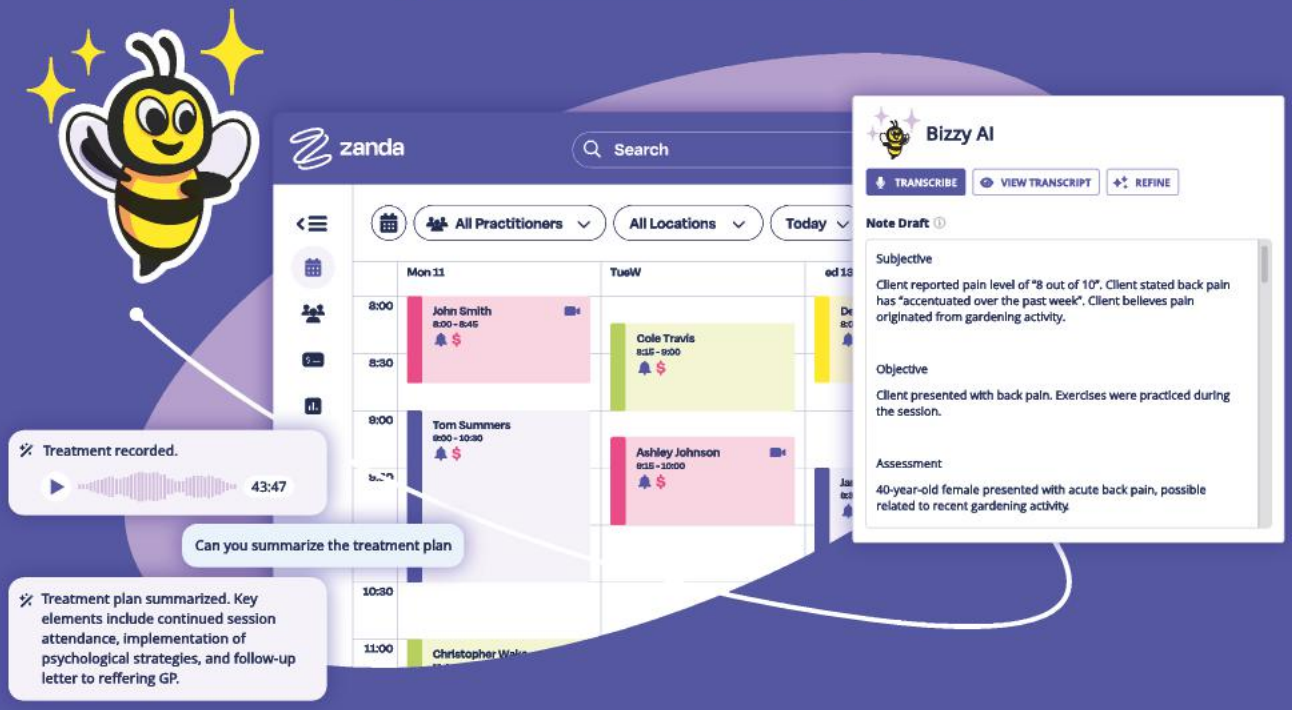


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MEMBER SPOTLIGHT

# The business of therapy

**Nicola Dixon-Grainger MBACP (Accred),** person-centred therapist and supervisor

**You're an award-winning King's Trust mentor offering business coaching. Is there a crucial business tip you would offer therapists?**

It helps to think of your counselling practice as the foundation for creating that safe space for your clients. If your business is dependable, durable and consistent, then that will translate into your client work. Create a regular, separate time slot for maintaining your business, and keep on top of your practical work demands. Being organised and structured will contribute to the smooth running of your practice on a day-to-day level and will ultimately reduce stress at pressure points like tax return deadlines.

**How do you integrate your therapy work with your other roles as a researcher in health psychology, lecturer, former course leader and nutritionist?**

I pay close attention to current issues, both in terms of what's happening in the news and what's making my classroom chatter, and also what's regularly presenting in my counselling practice. I research how these trends are impacting client groups, which then informs my clinical work. As a qualified nutritionist with 13 years of practice in the field, I also use my experience as a support for clients with food-related distress.

**Can you explain the links between your interest in history and therapy?**

At first glance these disciplines may look unconnected but they inform my practice. I did an undergraduate degree in history, and during my studies I became interested in the space between psychology and the human doctrines of history, archaeology and anthropology. I see behaviour patterns in ancient civilisations that are paralleled in our modern world. People essentially have not changed. We have the same emotions, motivations and brains as our ancestors. Understanding our past helps me in understanding the present and to fit it into a wider context, both on a societal and an individual scale. I am interested in any discipline that sheds light on the human experience. Maintaining my interest in history is also part of my release valve from the rigours of clinical work, helping to keep me centred.

# FROM THE PRESIDENT

**Professor Lynne Gabriel OBE**

Spring, with its new growth heralding the blossoming of existing life, still feels a long way off. Metaphorically, however, are we seeing the bloom of a developing relational and dialogical approach to people's mental health and wellbeing? One that places relationships at the core and that recognises the impact of injustice, disadvantage and disenfranchisement on wellbeing?

Relational care appears to be gaining momentum worldwide. With developments such as 24/7 neighbourhood mental health centres in England, which developed in response to Government keen to see integrated care for every community, we could be witnessing (and indeed party to) a relational movement within community-based health and mental health provision. While counselling and psychotherapy have long been present in private practice, there is a more recent rise of therapy within organisations and the NHS.

As part of multidisciplinary, inclusive and accessible models of care, therapy professions have a lot to contribute to the processes of convening and collaborating across private, primary, community and mental health services. While dyadic care continues, there are opportunities for therapy practitioners to contribute to community contexts as part of interdisciplinary and interconnected provision. For example, as groupwork facilitators or relational therapists within multidisciplinary teams, we can extend and deepen the ways in which our profession supports the care of the four nations. So where next?

Lord Darzi's 2024 landmark investigation[1] into the state of the NHS starkly signals the way. That year there were 3.6 million people in contact with mental health services, up from 2.6 million in 2016, while referrals for children and young people increased by 11.7% annually from 2016, and perinatal mental health referrals were increasing by 23% annually. It was clearly time for change.

Doing things differently requires relational and dialogical shifts across all dimensions of mental health work. Counselling and psychotherapy professions can bring important people and relational skills, knowledge and abilities to that process. Cultivating ongoing flourishing of the budding UK and international multidisciplinary relational approach to mental health provision is critical. Importantly we can raise our game and contribution through this much needed relational movement. Watch this space.

1. Lord Darzi. Independent investigation of the NHS in England. Department of Health and Social Care; September 2024. www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england

# Enhance your practice with CFT training

**The Compassionate Mind Foundation are the leading international provider of Compassion Focused Therapy training.**

CFT is an evolution informed biopsychosocial and evidence based approach to mental health difficulties. It helps clients cultivate compassion focused brain states to address difficulties including shame, self-criticism, depression and anxiety.

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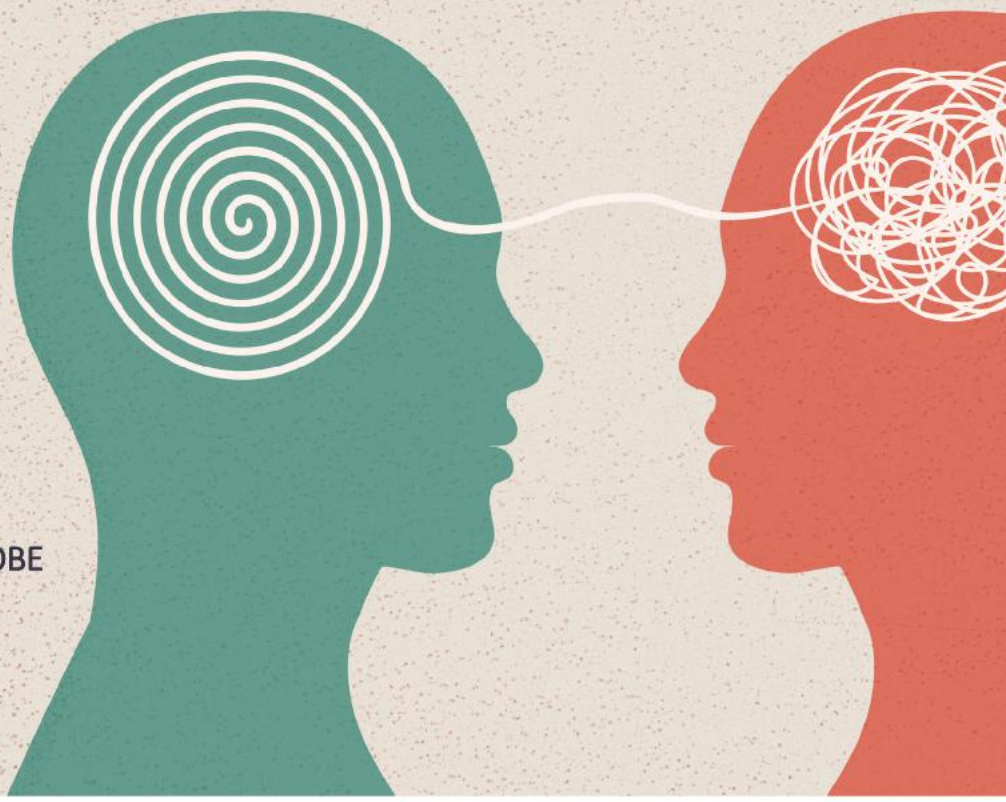

WORKSHOPS

DIPLOMA

THE Compassionate Mind FOUNDATION

# WORKING FOR YOU

## Update from BACP's Policy team

### Our response to refreshed NHS 10-Year Workforce Plan for England

With the demand for mental health support in the NHS still rising, we've urged the Government to consider the thousands of trained counsellors and psychotherapists ready and available to help expand access and improve patient care.

In our response to the Department of Health and Social Care's call for evidence on the refreshed 10-Year Workforce Plan, we highlighted that only 6% of our members currently work in the NHS, despite 66% expressing a desire to do so.


MATTHEW SMITH-LILLEY

We represent more than 60,000 qualified members and 10,000 trainees in England, many of whom have unused clinical capacity that could deliver up to 120,000 additional counselling hours per week if fully deployed.

If NHS England tapped into this capacity it would help it meet the country's growing mental health needs.

Matthew Smith-Lilley, our Policy and Engagement Lead (Mental Health), said: 'While the Government appears to be scaling back the major workforce expansion promised in the 2023 plan – placing more emphasis on technology and AI to drive productivity – there must still be a clear commitment to growing the psychological therapies workforce faster than the overall NHS average. This matters deeply.

'Access to psychological therapies is already below the level needed to meet rising demand, which continues to grow faster than workforce capacity. Our members have the skills, passion and experience to help close this gap and would transform care for thousands of people across the country.

'We will continue to advocate directly to Government and stand ready to work in partnership with the Department of Health and NHS England to ensure that everyone can access timely, effective mental health support.'


### Keep Britain Working report is 'important and timely'

We've welcomed the Keep Britain Working report's focus on prevention, early intervention and employer responsibility to address rising rates of sickness absence and health-related economic inactivity. Counselling and psychotherapy must be integral to any national response and not a peripheral add-on.

The report, led by former John Lewis boss Sir Charlie Mayfield, sets out a series of recommendations to address increases in people not working due to ill health.

One in five working-age adults in the UK are now outside the labour force. The main reason for this is ill health.

Kris Ambler, our Workforce Lead, said: 'The Keep Britain Working report is important and timely. We're pleased to see the strong focus on prevention, early intervention and employer responsibility. It's right to call for systemic action. But we must move beyond treating mental health as a productivity problem. Counselling and psychotherapy must be embedded at the heart of any solution, not treated as an afterthought. Therapy is essential to supporting people so they can work, helping recovery and building psychologically safe workplaces.'

- To find out more about how we're working on your behalf, see **bacp.co.uk/news/news-from-bacp**

## PROFESSIONAL CONDUCT

- **BACP's Public Protection Committee holds delegated responsibility for the public protection processes of the Register. You can find out more about the Committee and its work at bacp.co.uk/about-us/protecting-the-public/bacp-register/governance-of-the-bacp-register**
- **BACP's Professional Conduct Notices can be found at bacp.co.uk/professional-conduct-notices**


# Special rate insurance policy available for BACP members, provided by Balens

## Members have access to a special rate on a £6m professional, public and product liability policy.

- Full practitioner cover starts from **£57.35***
- Student cover starts from **£23.70***

*Including insurance premium tax and fees.

### Included in the policy:

- Cover for temporary work abroad (excluding cover for work in the USA and Canada).
- Cover for loss of reputation and client confidentiality protection.
- Legal and taxation policy with a limit of £100,000 per claim.

The policy is also on a claims occurring basis with a difference. It'll cover claims that occurred during the policy period irrespective of when the claim is made, meaning that you're protected for claims that may arise, providing the work was carried out during the period of insurance.

Terms and conditions, limitations and exclusions apply.

To find out more visit: **www.bacp.co.uk/insurance**

* It's your responsibility to assess the suitability of any insurance policy to meet your individual requirements. We're not responsible or liable for any loss or damages of any nature whether direct or indirect including any loss of profits or any consequential damages suffered or incurred as a result of you using a product or service.

bacp | counselling changes lives

# RESEARCH DIGEST

**To mark Time to Talk Day on 5 February, this issue focuses on research around barriers and facilitators in accessing counselling and psychotherapy.**

## 1 Autistic adult experiences of accessing therapy

**THE STUDY:** The current study sought to explore the experiences of eight autistic adults regarding barriers and facilitators in psychotherapy.
**THE FINDINGS:** The study used the enhanced critical incident technique where participants report factors that have enhanced or hindered an experience. Participants aged 23 to 63 with a diagnosis of autism spectrum disorder took part in interviews from which 147 'critical incidents' were extracted. The facilitators of positive therapy included: being treated with trust and respect, pragmatic approaches/interventions, continuity of care and practitioner knowledge of autism. Barriers included familial pressure and a lack of both publicly funded therapy and structured, individualised care.
**THE TAKEAWAY:** Positive experiences of therapy are possible for autistic adults and can be facilitated by learning directly from their valuable experiences and insights.
**READ MORE:** Jubenville-Wood T et al. Facilitators and barriers in psychotherapy from the perspective of autistic adults: an enhanced critical incident study. **bit.ly/3XJD0J1**

## 2 Integrating refugee clients

**THE STUDY:** A small proportion of refugees in high-income countries receive regular psychotherapy. A survey was conducted with 2,002 psychotherapists in Germany about treatment barriers and integrating refugees into regular psychotherapeutic practice.
**THE FINDINGS:** Half of the psychotherapists reported that they do not treat refugee clients, and for those who did, therapy was on average 20% shorter than for other clients. Negative correlations were shown between psychotherapists' overall perception of barriers and the number of refugees treated and sessions offered. The main barriers pertained to language-related issues and lack of contact with the refugee population.
**THE TAKEAWAY:** The integration of refugees into regular psychotherapeutic care could be improved by measures to connect psychotherapists with refugee patients. Increasing the provision of trained interpreters as well as ensuring there is coverage of therapy, interpreter and administrative-related costs can support increased provision of therapy to refugees.
**READ MORE:** Dumke L et al. The role of psychotherapists' perceived barriers in providing psychotherapy to refugee patients. **bit.ly/4iOzEhr**

## 3 Engaging people with psychosis

**THE STUDY:** Disengagement from psychological therapies among people suffering with first-episode psychosis (FEP) is common and associated with adverse early recovery and long-term psychological outcomes. The current study sought to undertake a systematic review of existing qualitative research to identify barriers and facilitators in therapy engagement among people presenting with FEP.
**THE FINDINGS:** Twenty-three eligible studies were critically appraised. Seven themes were identified as barriers to engagement in psychological therapy: ambivalence to therapy, emotional distress, fluctuating symptoms, negative expectations, physical capacity, service limitations and unmet therapy preferences. Six themes were identified as facilitators to engagement: destigmatising, accessibility of digital therapy, positive expectations of therapy are met, service factors, therapists interpersonal skills, and therapy preferences are met.
**THE TAKEAWAY:** Engagement is a multifaceted construct that depends on the individual's experiences and impacted by emotional, social, practical and service-level factors.
**READ MORE:** Fahy L et al. Barriers and facilitators to engagement in psychological therapy in first episode psychosis: a meta-ethnography and qualitative comparative analysis. **bit.ly/3MBIC5A**

# MY RESEARCH

**Dr Eva Fragkiadaki**
Senior Lecturer in Counselling Psychology and Co-Programme Leader of the Professional Doctorate in Counselling Psychology, University of the West of England, Bristol

**Eva tells us about her research work focusing on the psychological treatment of chronic health conditions.**

My research journey began during my undergraduate studies, in a positivistic, traditional psychology environment. During my doctorate in Counselling Psychology I started to explore therapists' experiences and psychotherapy processes using qualitative and reflective ways of doing research.

Over the years I worked on projects with colleagues in the UK, Europe and the US. These collaborations helped me shape my research path, focusing on chronic health conditions and psychological interventions. I became especially interested in the relationship between depression and multiple sclerosis (MS) and began spending time with people living with MS to hear what helped and what didn't when accessing psychological support.

These conversations and conclusions, combined with insights from practitioners, experts by experience and the wider literature, led to the development of MyMS-Ally, an integrative group psychological intervention for people living with MS. A small pilot study offered rich, longitudinal, qualitative data. We learned that change is deeply individual, process often matters more than content in groups, and wellbeing is about far more than symptom reduction. Our next steps involve exploring how to further personalise psychological support to the needs and preferences of people living with MS.

What has shaped me most is the generosity of the people who shared their time, stories and perspectives for my projects. Their input has shown me that meaningful research must be grounded in lived experience and real-world needs. I am committed to continuing this learning and research through participatory and embodied methods, working with disabled people and those with long-term conditions – communities that are still underserved in psychotherapy research. My hope is that we keep moving towards research and practice that are more inclusive, accessible and open to challenging ableism, stigma and discrimination.

# On Board

## With new Trustees joining BACP, members new and old share their reasons for taking on the role

**Erin Stevens**
(she/they) MBACP

**Tell us about you.**
I am Erin, a therapist, supervisor, trainer and consultant working in private practice in West Yorkshire and online. I specialise in working with people who have been harmed in therapy, and therapists who are concerned or curious about harm in practice.

**When and why did you join the Board?**
I joined the Board in November 2025. Having been a 'critical friend' of BACP for a number of years, now feels like the right time to step into a more active role in shaping the future of the Association. This feels like a pivotal moment for BACP – in my view there has been justified criticism and concern about events of the past few years, and change is clearly needed. My primary aim in standing is to be part of moving BACP towards a position that members can recognise as being rooted in integrity, transparency and a genuine (not performative) willingness to listen and hear.

**What do you aim to bring?**
I believe that the decision taken by the membership to elect me is connected to my commitment to anti-oppressive thinking and practice. BACP's continued support of the Memorandum of Understanding on conversion therapy, and some of the work being done around anti-racism, are promising, and I know that the membership also need to see that BACP is reflecting on how oppression shows up 'in here' as well as 'out there'. I am determined that this should be an embedded part of BACP's thinking and action as we move forward. I'm delighted to be elected, and looking forward to seeing what we can achieve.

**Olubumi (Bumi) Akinmutande**
MBACP (Accred)

**Tell us about you.**
I am an integrative clinical supervisor and counsellor, a mediator and an accredited public sector complaints manager. My career spans several decades of leadership within healthcare. I have worked at strategic levels to influence change, strengthen governance and improve the experiences of service users.

My therapeutic specialisms include bereavement counselling and Employee Assistance Programme (EAP) provision. In my supervision practice, I support both trainee and qualified practitioners, focusing on helping them thrive in their professional roles.

I am also the founder of VIADCOMS EAP and wellbeing services, where I work with organisations to build resilience, embed compassionate workplace cultures and support the wellbeing of employees.

**When and why did you join the Board?**
I joined the Board in November 2025. Several areas are especially close to my heart. With a long background in healthcare complaints management, I care about encouraging systems that are compassionate, fair, prompt and genuinely supportive. Complaints processes should promote genuine learning and improvement without instilling fear or creating a daunting atmosphere for therapists.

I am also passionate about beginning sector-wide conversations on how trainees can be fairly remunerated. Training to become a therapist is resource-intensive, yet clinical placement hours are unpaid. Other clinical professions are paid a wage during placements. Counselling trainees should not be an exception. They are trained professionals too.

I also believe strongly in advocating for counsellors to be recognised alongside other health and social care professionals. Our skills, training and contributions to public wellbeing deserve equal visibility and respect.

**What do you aim to bring?**
I bring more than 27 years' experience designing and delivering compassionate complaints management systems and training programmes. My work has consistently focused on ensuring that both staff and service users feel supported, heard and cared for. I have built a career on diplomatically and patiently advocating for meaningful and lasting change, and I look forward to bringing this same commitment to my role on the Board.

**Matt Cormack**
(he/they) MBACP (Accred), RegCOSRT

**Tell us about you.**
I'm an integrative psychotherapist, supervisor and psychosexual and relationship therapist. I have worked and volunteered with many LGBTQ+ organisations over the years. I am a clinical associate of Pink Therapy and

predominantly work with GSRD or neurodivergent clients. I conducted the first research into autistic people's experience of psychosexual therapy, which has been submitted to a journal for peer review.

I have previous experience within BACP where I sat on the Spirituality Division. I was the counselling lead for Edinburgh College and worked as a counsellor in further education for years.

**When and why did you join the Board?**
I was recently elected by members of BACP and formally joined the Board at the AGM on 6 November 2025. I stood for election for several reasons but there are two key areas for me. BACP does a lot of fantastic work – however, I know that some members feel frustrated at communication and decisions from BACP. I want to improve communication and transparency with members. My other primary motivation is to help therapy be safe and more accessible for clients, particularly clients from disadvantaged or minoritised backgrounds.

**What do you aim to bring?**
I'm aiming to help bring stability and to start rebuilding trust with members, which I've seen become damaged over the years. A part of this will involve acting as a critical friend to BACP and asking challenging questions so that we can make meaningful changes for moving forward.

## Ewan Irvine
MBACP

**Tell us about you.**
I'm a counsellor committed to supporting people from all walks of life to explore their emotional worlds with honesty and compassion. I work with a broad range of clients and presenting issues, and I'm continually inspired by the courage people show when they choose to engage in therapy. While I have a particular interest in men's mental health, my work is grounded in the belief that everyone deserves a space where they can be heard, understood and supported without judgment.

**When and why did you join the Board?**
I joined BACP's Board in 2022 because I wanted to contribute to the profession in a way that extends beyond direct client work. This felt like an opportunity to help shape the future of counselling and psychotherapy at a time when the demand for accessible, ethical and high-quality support is greater than ever. As a Board, we've navigated some tough challenges along the way, but those experiences have strengthened our resolve and reminded us that it is the future that truly counts – for members, for clients and for the profession as a whole.

**What do you aim to bring?**
I aim to bring a practitioner's perspective, a commitment to inclusion and a thoughtful, reflective approach to governance. I'm particularly interested in how BACP can continue to widen access to therapy, strengthen public trust and support practitioners at every stage of their professional journey. Above all, I hope to contribute steady, compassionate leadership and a willingness to listen deeply to the people we serve.

## Josephine Bey
MBACP (Accred)

**Tell us about you.**
When I look back at my career, what runs through all of it is a commitment to psychological safety, inclusion and the belief that people thrive when their whole selves are recognised. I began my professional life in anthropology, moved into therapeutic work, and over the past decade have held roles ranging from psychotherapist and supervisor to clinical director and mental health consultant. Whether responding to national crises, supporting frontline safeguarding teams or working with students just beginning their therapeutic journey, I've always been drawn to the places where complexity, identity and meaning intersect.

**When and why did you join the Board?**
I joined the Board in 2023 because I believe deeply in the future of our profession and the responsibility we hold in shaping it. Having led large-scale services and contributed to organisational strategy, I wanted to bring a perspective grounded in both clinical governance and equity – ensuring that safe, reflective, culturally attuned practice sits at the heart of how we serve our communities. I was also motivated by the opportunity to contribute to systems-level thinking: how we evolve as a profession, how we widen access and how we ensure the next generation of therapists is supported with integrity and care.

**What do you aim to bring?**
I aim to bring a combination of strategic experience, transpersonal and systemic thinking, and a commitment to inclusion that goes beyond policy into lived practice. As a therapist, what I cherish most is witnessing people rediscover agency, meaning and connection. It's a privilege that continues to shape both my work and the values I bring to the Board.

## William Llorel-Antoine

**Tell us about you.**
My life has a lot of variety. In recent years I have trained as a clinical wilderness therapy guide and a facilitator for domestic abuse perpetrators. The bulk of my professional life before this has been

***'We've navigated some tough challenges along the way, but those experiences have strengthened our resolve and reminded us that it is the future that truly counts'*** **Ewan Irvine**

working in risk and organisational consulting, where I've worked with boards, executives and mission-driven organisations through a psychodynamic lens to design inclusive governance structures that foreground responsibility, accountability and impact. In recent years my work has expanded.

A couple of years ago a teacher of mine posed the question: how do want to contribute to the world as it is? This is a question that I try to frame my personal and professional life around. So hopefully I have many hats and one persona.

**When and why did you join the Board?**
In May 2025 I joined the Board after serving several years on the Finance, Risk and Audit Committee. This provided me with a deep appreciation of BACP's mission and purpose as well as an understanding of the Association's nuances. With a permanent and engaged senior leadership team I was inspired to take a more direct role in embedding our governance improvement programme. I look forward to seeing the ways in which we can increase our reach.

**What do you aim to bring?**
My hope is that BACP can model an organisational structure that serves its members and sets an inclusive and equitable governance standard. On the horizon I would love to work with members reaching clients in expansive ways.

## David Chenery

Chair of the Finance, Risk and Audit Committee

**Tell us about you.**
I recently retired from a career immersed in finance and financial governance (36 years with Barclays Bank and then 19 years in the charity sector, the last 12 years as National Manager for Finance Governance with Age UK).

**When and why did you join the Board?**
I joined the Board as an appointed Governor in June 2024, having responded to notification of a vacancy for Chair of BACP's Finance, Risk, Audit, Policy and Performance Committee (FRAPP) on the Reach Volunteering website.

I felt that the role would enable me to make good use of my wide experience in an organisation that supports services that are so very vital in today's difficult world.

One of my children is a clinical psychologist and another is a senior leader in a mental health trust, so I have insight into the demands made of the therapy profession. While I do not have any personal qualification or experience in this field, I can use my skills, knowledge and experience of financial governance in both the charity sector and the commercial world to help BACP continue to support its members around the UK.

**What do you aim to bring?**
A deep understanding of financial governance is not necessarily a key requirement in a therapist's range of knowledge and experience, so if I can help by ensuring that BACP is, and remains, a financially sustainable organisation that can continue to support its members then my small contribution will be worthwhile.

## Dr Paul Taylor

Chair of the Public Protection Committee

**Tell us about you.**
I am Head of the School of Humanities and Social Sciences at the University of Chester. Before moving into higher education I worked in the construction industry and then in NHS acute mental health in-patient services. These experiences, alongside my academic work in criminology, sociology and mental health, have shaped a career focused on how systems protect (or fail to protect) people at their most vulnerable while also understanding the lived experience of those in the professions.

**When and why did you join the Board?**
I joined as a lay member, and became Chair of the Public Protection Committee in November 2025. I was drawn to BACP's commitment to ethical, accountable practice and the impact counselling and psychotherapy have on individuals, families and communities. Joining the Board is a way to contribute governance and public protection experience to a profession that supports wellbeing.

**What do you aim to bring?**
I aim to bring a rigorous, evidence-informed perspective to public protection, asking constructive questions about risk, fairness, proportionality and transparency. I hope to support the Board in balancing member interests with wider public good and to strengthen BACP's role in conversations about regulation, standards and public confidence. ●

## Full list of Trustees

- **Olubumi (Bumi) Akinmutande**
- **Josephine Bey**
- **David Chenery**
- **Matt Cormack**
- **Emma Farrell***
- **Emily Garvie***
- **Ewan Irvine**
- **William Llorel-Antoine**
- **Erin Stevens**
- **Dr Paul Taylor**

**Unable to contribute to this article due to personal circumstances.*

***'I was drawn to BACP's commitment to ethical, accountable practice and the impact counselling and psychotherapy have'*** **Dr Paul Taylor**

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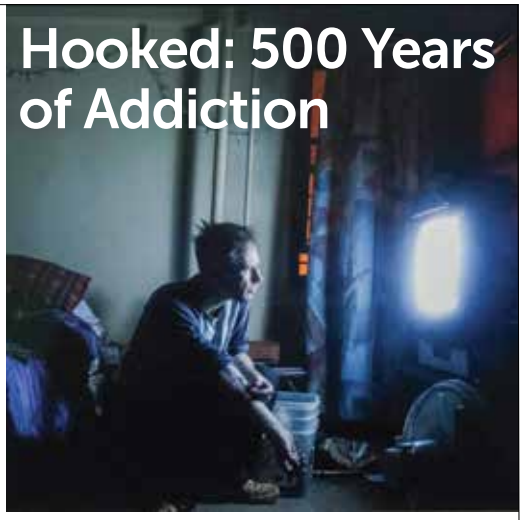
# What's on

Mental wellbeing in the arts and media

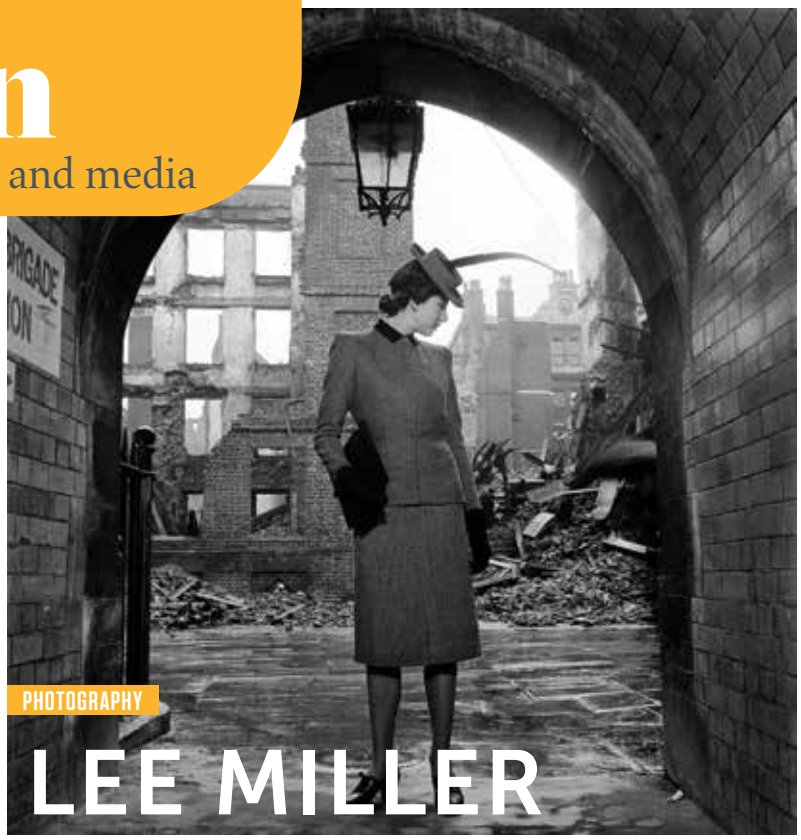
EXHIBITION

## Hooked: 500 Years of Addiction



© GRAHAM MACINDOE

Now in its final fortnight, this free exhibition in Edinburgh looks at the history of addictive substances in the UK as well as the prevalence of addiction. From modern-day vices such as alcohol and cigarettes to habits of the past such as snuff, *Hooked* finds clear links between the problems we face today and the policies and oversights of British colonialism. Some of the exhibits are curious: cartoons about 'intemperance' and a sumptuous smoking jacket. Others look more closely at the humanity and loss for people trapped in substance use: Graham MacIndoe's *Coming Clean* photo series is a particular highlight. At Physicians' Gallery in Edinburgh until 13 February.



PHOTOGRAPHY

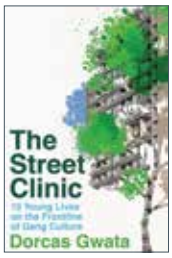
## LEE MILLER

LEE MILLER/LEE MILLER ARCHIVES, ENGLAND 2025. ALL RIGHTS RESERVED. LEEMILLER.CO.UK

Photographer Lee Miller almost entirely stopped taking photos when she came back from covering World War II, and lived with symptoms of PTSD and alcoholism until her death. But during the war, as the first woman to get accreditation as a photographer from the US Army, she changed war journalism. Her work remains one of the most iconic and influential accounts of World War II that we have today. Miller brought her training and experience with the symbol-laden imagery of surrealism to bear on such photographs as *The eyes of Sibiu* and *In Hitler's bathtub*. It meant her shots spoke directly to the collective unconscious about our fear of fascism, the strangeness of war, and our need for curiosity and irony – especially in dark times. Catch *Lee Miller* at Tate Britain until 15 February.

## Social contexts

BOOKS




In *The Street Clinic*, coach and mental health nurse Dorcas Gwata's case study-led account of treating young people on the fringes of gang crime twists and turns as it tells their stories. Issues such as the role of community, or sexuality in young people's inner lives, are handled with curiosity and dedication. (Picador, out 12 February)


Sociologist Elizabeth Cotton examines the rise of digital therapy and the pitfalls that it creates for both therapist and client. Readable and witty, *UberTherapy* is also a rallying cry for therapists who want to survive the automation and commoditisation of their industry. (Bristol University Press, out now)


Coach and writer Anna Katharina Schaffner knows the plots we use to cope with adversity well – and the counternarratives that produce different endings. Splitting these stories into 'me' and 'the world' sections, *The Story Solution* pushes readers to try and thrive when they apply what they learn. (Profile Books, out now)

**Compiled by Ellie Broughton**
Email details of events to
therapytoday@thinkpublishing.co.uk

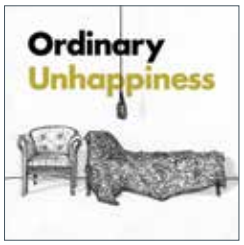
ART

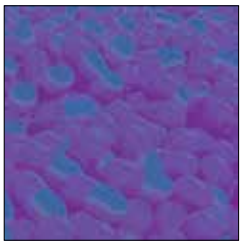
# Rae-Yen Song

PHOEBE WINGROVE

Glaswegian artist Rae-Yen Song has filled the city's Tramway gallery with deeply personal visual art inspired by family history and ancestral beliefs. Iconic Chinese dragon imagery informs a hanging centrepiece; elsewhere, a mysterious blue figure hangs from the ceiling, a colourful costume glows in the corner and a surreal animation shows a lifecycle in a strange habitat. Family life is present throughout, balanced with the artist's interest in Chinese myth and folklore, and their sense of identity as a member of the Chinese diaspora in Scotland. The two themes come together within a Daoist view of humanity's place in the wider ecosystem. At Tramway until 16 August.

PODCASTS

# Power and vulnerability

Former officer Paul Cooper explores workplace trauma within the police force in *Pocket Sergeant*, a unique podcast from the frontlines of UK policing. From postnatal depression to coercive control, Cooper tackles unexpected topics from a workforce that rarely shows its vulnerable side. On Apple Podcasts.
**bit.ly/46SukEq**

In a recent episode of the psychoanalysis podcast *Ordinary Unhappiness*, authors Nick Stock and Nick Peim join hosts Abby and Patrick to delve into the role of the teacher in fiction and reality. They ask what drives people to teach, and what our projections onto teachers tell us about our fantasies of learning. On Apple Podcasts.
**bit.ly/47unxkr**

In this episode of *Red Medicine*, writer Lily Scherlis discusses her essay for *n+1* magazine about attending one of the Tavistock's Group Relations Conferences, and what she learned about Wilfred Bion's work – and herself – during the process. With host Sam Kelly, Scherlis also talks about the role of group relations work in activism.
**bit.ly/3WWXZaH**

FILM

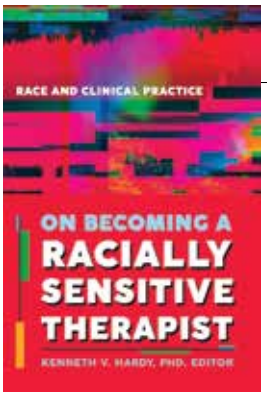
# My Father's Shadow

LAKIN OGUNBANWO/BBC FILMS

A story of two young brothers in Lagos, Nigeria during the 1993 coup, Akinola Davies Jr's film is a tender ode to memories of a homeland. Co-written with Davies's brother Wale, *My Father's Shadow* takes place over the span of a single day. For the writers it's also a loving memorial to their own beloved father. Though written and directed by British-Nigerian brothers, the film was produced by a Lagos-based company, Fatherland, whose mission is to bridge the gap between creatives in the diaspora and producers in Nigeria. By doing so Fatherland lifts up untold stories and remembers events that still resonate today. On general release from 6 February.

# Bookshelf

**Edited by Jeanine Connor.**
Please note, we do not accept unsolicited reviews.




**On Becoming a Racially Sensitive Therapist: race and clinical practice**
Kenneth V Hardy (ed) (WW Norton)

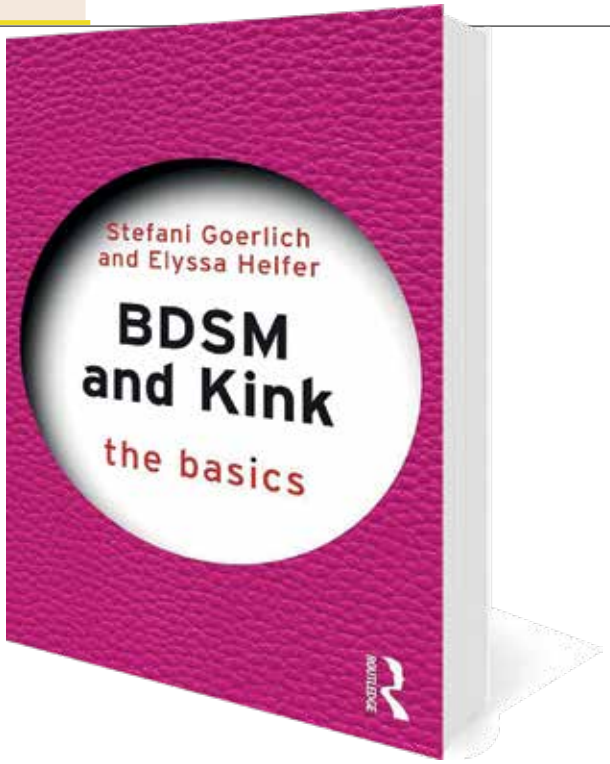
This lucid and compelling book about the centrality of whiteness in society generally, and the therapeutic industry in particular, left me spinning.

It details principles for dismantling the 'therapeutic' way of working that flows from this organising system. Hardy suggests all therapists should become 'racially sensitive', which involves getting to know your racialised self, and should develop skills to create a therapeutic space where discussion of race is welcome and encouraged.

The book charts the experience of therapists deconstructing systematic oppression in their practice. Their aim? To minimise their role in replicating the devastating order we live by. For people of colour, the focus might be 'soul work', to locate yourself after a lifetime of being devalued. For people who are white it means examining your whiteness and role in oppression. The final section, on therapeutic issues and approaches, includes a searing account of racial harm in a coaching relationship.

Written in a North American context this framework can be applied to Britain, given our linked colonial history. The challenge to how we teach, learn and 'do' therapy is wholesale. If you don't finish reading this book feeling overwhelmed but convinced about the urgency of this work, it's worth examining your response. This book sets out exactly how we, and our clients, are affected by (in)attention to race.

**Zorana Halpin MBACP (Accred), counsellor**




**BDSM and Kink: the basics**
Stefani Goerlich and Elyssa Helfer (Routledge)

For any therapist with a desire to find out more about sexual and relationship diversity and offer a kink-affirmative approach, this book is a great place to start. The authors, both sex therapists, share their comprehensive knowledge in this concise, well-researched and well-meaning volume. The book is presented in 10 chapters, covering the sexual practices of kink, bondage and discipline, dominance and submission, sadomasochism and fetish. Chapters include historical and cultural considerations of kink as well as definitions and signposts to further reading, including QR codes for easy access to podcasts and resources – a contemporary addition I've not come across in reference books before.

From a therapeutic perspective, the sections I found most valuable were those pertaining to best practice and assessment of risk as well as the authors' thoughts about what constitutes 'problematic behaviour'. Spoiler alert: not very much. They emphasise pleasure and consent, asserting that problematic sexual behaviours are those which are non-consensual, or cause significant personal distress or impairment. They encourage kink-affirming therapists to centre client agency and autonomy, viewing the client as the expert in their own experiences and desires, in keeping with a client-centred approach to any other type of presentation. Compassion and curiosity are our best tools along with congruence and comfort in normalising discussion of sexual practices. This is a superb book that I will refer to each time I welcome a new kinky client.

**Jeanine Connor MBACP, psychodynamic psychotherapist**

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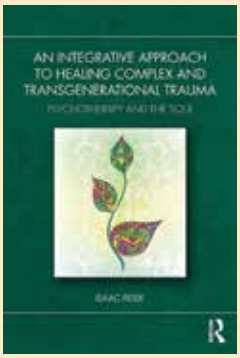
*'Hardy suggests all therapists should become "racially sensitive", which involves getting to know your racialised self'*

**Zorana Halpin**



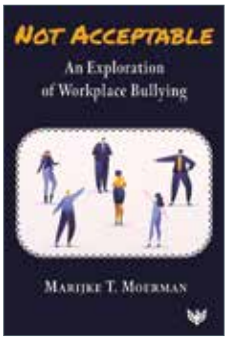

**An Integrative Approach to Healing Complex and Transgenerational Trauma: psychotherapy and the soul**
Isaac Pizer (Routledge)

Everyone has a transgenerational history and for many it is a traumatic one. Yet addressing transgenerational trauma in psychotherapy is a relatively new concept, with both theory and practice still at an early stage of development, so I was delighted to have the opportunity to review this book.

The author outlines his philosophical and transpersonal stance. His integrative-relational model derives from a wide theoretical base, including psychoanalysis, Gestalt and constellations work, illustrated with case material throughout. I enjoyed reading the opening chapter – a reflective account of Pizer's own journey through transgenerational trauma arising from his Jewish background.

The most interesting section for me was 'The transgenerational dimension in practice' that highlights varied and creative approaches for working with scenarios including war, refugee status, migration, bereavement, injury and unhelpful parenting. There are clear examples of situations that were unresolved in one generation being subsequently transmitted to the next.

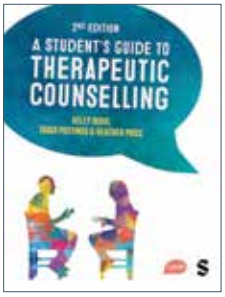
At times I found the text a little dense, but this is an intelligent and thought-provoking read with its key message being the need to attend to and address the transgenerational. It is a well-researched book that introduces something novel and valuable into the field, and I highly recommend it to qualified therapists, trainees and anyone with an interest in exploring transgenerational therapy.
**Anne Gilbert MBACP (Snr Accred), Gestalt psychotherapist**




**Not Acceptable: an exploration of workplace bullying**
Marijke T Moerman (Karnac)

This book is a sensitively written exploration of the types of bullying that occur in the workplace, framed by the author's experiences of being bullied herself. Moerman refers to a model of power and control commonly used in understanding domestic abuse to demonstrate how behaviours such as intimidation, emotional abuse and minimisation are used by workplace perpetrators to manipulate the target of the bullying. The author's use of 'target' rather than 'victim' feels ingenious to me as she explains it is more empowering. She also explores the narratives of six individuals who have been targets and bystanders of workplace bullying, providing insightful first-hand perspectives. The section on the legal perspective of workplace bullying around the world provides context on how the law can support the target.

The author is a person-centred therapist whose modality underpins the tone of the book, and reading it felt like being spoken to by a compassionate, empathic friend who has survived workplace bullying and is using her experiences to help others. This is a valuable resource to help individuals affected by workplace bullying make sense of their experiences in a holistic, validating way. As a therapist the first-hand perspectives of targets and bystanders helped me to understand that workplace bullying has enduring consequences far beyond the workplace.
**Dr Angelina Archer MBACP, counselling psychologist**




**A Student's Guide to Therapeutic Counselling (2nd edition)**
Kelly Budd, Traci Postings and Heather Price (Sage)

Student members looking to invest in a reliable guide to training as a counsellor should consider this book. Written mainly with trainees at Levels 4 and 5 in mind, with some specific references to the Counselling and Psychotherapy Central Awarding Body (CPCAB) training model, it gathers a range of relevant topics.

In terms of theory, the authors do a superb job in addressing core academic concepts, especially ideas that can be harder to pin down. An example is the section on explicit and implicit aspects of a client's process, a central idea in CPCAB courses, which are defined with clarity and explored with insight.

The same is true of the sections on difference and diversity and integrative practice. In terms of working with clients on placement, the essential topics are covered, and I have no hesitation in recommending this as a companion guide.

The authors write in a question and answer format, which reads like a dialogue between trainee and tutor. I like this departure from the usual textbook style, because the conversational tone makes it readable and relatable. I can imagine students at the beginning of their courses having their initial nerves settled. Such is the range and quality of the content, readers are sure to regularly return to it for guidance on specific issues throughout their training.
**Mark Williams MBACP, counsellor**

# One-click culture

## How should we respond to changing client expectations about therapy? **Sally Brown** investigates


Therapy is the 'profession of the century' according to a *Financial Times* report that asked 'Why are so many people retraining as therapists?'[1] BACP student membership has increased by 21.06% since 2021, and BACP general membership is at an all-time high of 75,263.

It's perhaps not surprising given that awareness of the importance of mental wellbeing has risen, and having therapy has become destigmatised to the point of almost becoming a status symbol in some circles. The UK has also never been more therapy-literate, with information about emotional and psychological health now widely available via social media channels and AI. Therapeutic thinking and theories such as attachment styles, trauma, projection, anxiety and neurodiversity are no longer confined to the therapy room – they're discussed in the workplace, schools and further education institutions, and in wider society, validating the relevance of our expertise.

Some therapists are experiencing a boom time as a result – over a third (36%) of respondents to a recent BACP Mindometer survey described demand at their practice as overcapacity, resulting in a waiting list or referral of clients to other services.[2] But something more surprising is also happening in response to this changing professional landscape – many have seen enquiries slow down. 'I've been a lot quieter this year in my private practice, and sometimes wonder if AI is the reason', 'Is anyone else finding it ridiculously quiet at the moment?' and 'Enquiries have dropped – is anyone else constantly anxious it's all going to disappear?' are just a selection of recent posts in therapist Facebook groups. Although there are no hard data, it's been suggested that an increased number of people qualifying as therapists means more competition, with some areas reaching saturation point with private practitioners. Factor in the cost of living crisis and the AI effect – people turning to chatbots instead of therapy for support – and you begin to see why even established practitioners are reporting a noticeable decrease in new client enquiries.

It's not just competition with colleagues that is presenting challenges – we're also struggling to stay visible. Traditional therapist directories now have to compete with the

***'We'd notice clients coming in already fluent in therapeutic discourse but somehow they were more stuck than ever'*** **Chris Hoff, therapist, academic and author**

KIRSTEN SHIEL

*'Clients want options. Courses, groups, stand-alone sessions, hybrid models – these aren't us "selling things" so much as responding to a genuine need'* **Sarah Rees, private practitioner and author**

marketing budgets of the large subscription-based online therapy platforms. Private practitioners are also navigating ever-changing algorithms to remain findable when clients search for support on Google, social media platforms and via AI.

Therapists are also reporting a shift in clients' perception and experience of therapy. Clients expect to 'know, like and trust' a therapist before they even book, and are shopping around for therapy. They're just as likely to choose a practitioner from their social media presence than their directory listing. When they turn up for their first-ever therapy session it's often with a preset agenda, to discuss or confirm (for example) a 'TikTok self-diagnosis' of parentification, narcissistic abuse or anxious attachment.

If there is one word that describes what's happening in the current therapy landscape it's 'disruption', and although change is often unsettling, disruption can create growth and new opportunities. Digitalisation has opened up new ways for therapists to reach more clients and scale up their practices. Social media allows therapists to clearly communicate their specialisms to the clients they work best with. And thanks to the normalisation of seeking help for mental health issues, there are potentially more clients out there than ever before.

The question for us as a profession is how do we respond and adapt to this changing landscape without sacrificing professional ethics and losing the essence of what we do? The answers aren't straightforward, but to offer some insight, I talked to key practitioners and academics about the emerging trends impacting our profession, and how we ethically and practically navigate the challenges facing us right now and in the immediate future.

## Ambient culture

The days when the only option for mental health support was seeing the counsellor at your GP's surgery, or choosing from the few private practitioners working locally, are long gone. Clients can now draw on a broader range of resources – they can book online sessions with therapists throughout the country while also using a mood-tracking app, participating in an online peer community, following several mental health influencers on social media and regularly talking to ChatGPT about their worries.

Therapy is everywhere now as 'ambient culture', says therapist, academic and author of the Liminal Lab Substack Dr Chris Hoff (**theradicaltherapist.com**). 'People are "holding space", they're "trauma-informed", they're talking about "nervous system activation".' Hoff calls the phenomenon the 'great dispersion' and says what he's noticed is that clients who present as fluent in 'therapy speak' are also more likely to be stuck: 'I'd be in supervision or consulting with colleagues and we'd notice clients coming in already fluent in therapeutic discourse – trauma-informed, attachment styles, nervous system regulation – but somehow they were more stuck than ever. They'd done all this ambient therapeutic work through podcasts, self-help books, Instagram and TikTok and were arriving exhausted, having self-diagnosed and self-treated but unable to actually shift anything.'

The challenge for our profession, says Hoff, is that an entire generation expects therapy to feel good, to be empowering, to affirm. 'They expect immediate validation and psychoeducation – the TikTok model rather than the slower, often messier work of actually changing how they story their lives. But real therapeutic work often requires exactly the opposite – sitting with contradiction, tolerating not-knowing. When clients have been fed a steady diet of ambient therapy that promises clarity and resolution, the actual uncertainty of transformative work may feel like failure.'

It's not just younger generations. Thanks to 'the algorithm', anyone with an online life is, intentionally or otherwise, shown a curated version of the news and social media that interests them and affirms their views. 'I do think we are all curating our own echo chambers now, and that extends into therapy,' says Louise Chunn, founder and CEO of the therapist-matching platform Welldoing. 'Some people want a therapist who reflects their views and won't challenge certain assumptions. The whole language of "safe spaces" can sometimes feed into that, if "safe" means "never disagrees with me".'

John Wilson, psychotherapist, trainer and Director of Onlinevents, agrees it is a challenge but also sees it as a time to rethink where we best add value. 'The entry-level kind of contact with clients – a little bit of reflection and a supportive space – the AI models are already very, very good at that. Millions of people are using AI for that every single day. That ship has sailed,' he says. Rather than seeing this as a threat, Wilson frames it as 'a call to excellence'. If AI can handle basic reflection and support, human therapists need to excel at what machines cannot do – the deeply embodied, human-to-human sensing of what's happening in another person. 'That's the bit that AI can't get into right now,' he says.

That doesn't mean, however, that we shouldn't also adapt and offer clients what they are asking for – and for some that might mean working at a faster pace, says Wilson. Along with Prof Windy Dryden he has been involved in training counsellors to

*'The entry-level kind of contact with clients – a little bit of reflection and a supportive space – the AI models are already very, very good at that'* **John Wilson, psychotherapist and trainer**


KIRSTEN SHIEL

deliver 20-minute 'micro-sessions' for a new subscription app, brightloaf. For years Dryden has offered demonstration sessions at training workshops, often lasting just 20 to 25 minutes. 'That taught me what is possible in a fairly short period of time,' he says. For a monthly payment brightloaf members get unlimited access to self-directed anxiety support, with the option to book 20-minute video sessions with BACP registered counsellors for an extra payment. 'People don't always want solutions to specific problems – some just want to talk for 20 minutes, and that's fine,' says Dryden. 'They might want some reassurance, they might want to know, "is this normal?".' Rather than replacing long-term therapy, Dryden sees microtherapy as adding to our repertoire.

Trained in the person-centred approach with its 'eye on a very long-term kind of experience', Wilson found himself struggling when clients didn't engage with that open-ended time frame. 'I would have people coming, getting a little bit of benefit and not coming back,' he says. 'So my practice started to shift into, well, what can we do today?'

This isn't about abandoning depth for convenience, Wilson insists – it's about recognising that we can offer something tangible in each session while remaining open to longer-term work. 'Clients shouldn't need to wait for us to warm up to them,' he argues. 'If there's something that we can do right away to make a difference in someone's life, and they can have that right now, why should they wait for us to settle into the relationship?'

## Mental health ecosystem

We may see the traditional, 50-minute, weekly therapy session as the gold standard treatment for mental wellbeing but increasingly clients are viewing it as just one option in the 'mental health ecosystem', says Terry Hanley, Professor of Counselling Psychology at the University of Manchester. 'Clients pick and mix from all over the place. They come to therapy and say "I talked to ChatGPT about this yesterday". They bring in their mood apps, their wearables monitoring different things. It presents a question for us as a profession – do we engage with this, and take some responsibility for what happens in between our sessions with clients, or not?'

Although there were other options for mental health support in the past, says Jodie Cariss, founder of the innovative London-based therapy service Self Space (**theselfspace.com**), what's changed is the sheer access: 'In the past we just had the agony aunt in the back of a magazine and a few self-help books in the library. Now we have this expansive wealth of options.' A key driver for clients seeking wider options is cost. 'Weekly private therapy from £50 to £100 or more per session, long term, is a serious financial commitment.'

Hanley sees an emerging role for therapists in supporting people to think critically about the quality of the tools they use, and also recommend safer options where appropriate, and integrate those experiences into therapy. 'We could respond by thinking that's happening outside the 50 minutes, nothing to do with me, I have no responsibility whatsoever,' he says, 'but we'd miss out on an opportunity to actually orchestrate some of that space a little more.'

If we think beyond the idea of one-to-one work being the only 'real' therapy, new opportunities to use our skills open up, argues Cariss: 'That might mean personal therapy where appropriate but also psychoeducational talks, walking groups, retreats, workplace workshops, thoughtfully designed digital resources – and allowing the client to curate their own therapeutic package. Our role is ensuring these elements work together to support real change rather than becoming a way to avoid it.'

## Diversification

It may feel like a threat, but the growth of the mental health ecosystem could make a therapy career more sustainable, according to Sarah Rees (**sarahdrees.co.uk**), private practitioner, therapy business coach and author of *A Therapist's Guide to Private*

***'Some clients are thinking about therapy and are not quite sure yet. We can really help them by having some kind of social media presence that allows them to get to know us a little'*** **Josephine Hughes, therapist and podcast host**

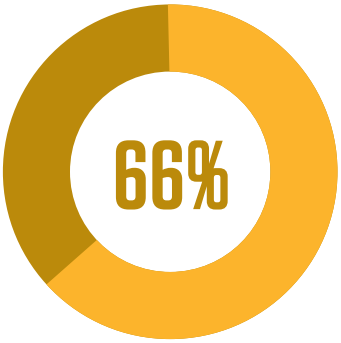
*Practice* (Routledge). 'We love the work but it can be exhausting, especially after many years. There are so many other ways people could access our knowledge. I think we're going to have to diversify, partly for our own wellbeing,' she says. 'It's a very different "energy bucket" to create a course or a digital resource than to see clients back-to-back. For clients, especially when there's shame involved, the leap from feeling ashamed to walking into a therapist's room is enormous. We can bridge that gap through guides, courses, workshops and so on – helping people move from wanting help to feeling ready to see a therapist.'

Rees ran a workshop for therapists on diversifying, tying it in with Black Friday, and was surprised at the demand. 'I worried it would feel gimmicky or too salesy and that no one would come. The response was huge. There's clearly a need – therapists want to use their knowledge differently, and clients want more flexible, hybrid ways of working. Clients are busy, and many want to explore other options before committing to regular sessions. That might be a 90-minute, one-off session where they can bring a problem, explore what therapy might look like and leave with recommendations and resources. The wider point is that clients want options. Courses, groups, stand-alone sessions, hybrid models – these aren't us "selling things" so much as responding to a genuine need.'

## Know, like and trust

Some changes in the therapy landscape reflect broader cultural shifts, such as the so-called 'trust recession'. It's one reason why therapists need to understand the 'know, like and trust' factor, says therapist and host of the *Good Enough Counsellors* podcast Josephine Hughes, who runs Therapy Growth Group (**josephinehughes.com**): 'If people are finding you online they need several "touchpoints" with you before deciding to work with you. Some clients are looking because they want help immediately, but many others are thinking about it and are not quite sure yet. We can really help that latter group by having some kind of social media presence that allows them to get to know us a little.'

Visibility is increasingly important for therapists, agrees Rees. 'In marketing terms




**of people have experienced at least one mental health issue in the past five years***

success used to be about who you knew, then it was what you knew and now it's who knows you. Therapists often put long lists of qualifications on their websites to attract clients, but most potential clients have no idea what those letters mean. Now clients want to know who the therapist is.'

How we show up digitally is becoming a reflection of how we show up in the therapy room, and it's ultimately empowering for the client, she believes: 'We lock so much expertise behind the therapy door, but we're asking people to trust us with their most private, sometimes darkest experiences. The research is very clear – outcomes are better when clients know, like and trust their therapist and feel confident that we'll look after them. That therapeutic relationship far outweighs the modality we use or how long we've trained for. And that relationship can start before they ever walk into the room.'

A well-written directory profile or website may no longer be enough – many therapists report that directory listings that worked well for years can no longer be relied on to consistently bring enquiries. Changes in Google's search results, the rise of AI summaries and the prominence of Google business listings all play a part. Although word of mouth, referrals and networking all still matter, social media meets an emerging client expectation to have 'seen something of us' before they book, says Rees. 'Therapists hate doing video, but it's a very effective way for people to get a sense of us,' she says.

Chunn agrees: 'Therapists now have the option to add short videos to most directory profiles, and they can be effective. A lot of therapists have been camera-shy, but many now have ring lights for video calls and a smartphone, so taking a decent video is not a stretch. At Welldoing we're currently experimenting with posting short, psychoeducational reels on social media, with therapists answering the questions people rarely voice: "Will my therapist judge me?", "Are they analysing me outside sessions?", "Are they bored by my problems?". It's not designed to replace therapy – it's designed to lower the threshold for making contact.'

## Vulnerability economy

The challenge for therapists is that creating and managing an effective and appropriate social media profile can feel like another job in itself – and as Rees points out, 'you're essentially investing your time in someone else's platform' and contributing to the profits of corporations such as Meta in the process. She also has reservations about what 'the algorithm' favours, as in general, posts containing controversial content tend to perform best. For therapists, whose work relies on compassion, thoughtfulness and containment, the pull towards 'shocking stats' and emotionally charged snippets can be dangerous. 'The platforms want people to stay, be shocked, be entertained. That's the content they reward. You could easily end up chasing shock value. We need to think carefully about the culture we're creating in private practice,' she says.

Alongside the visibility issue sits something subtler but more unsettling – a cultural expectation of self-disclosure. Across many fields we're seeing the 'marketing of vulnerability' – the entrepreneur who

***'Therapists now have the option to add short videos to most directory profiles, and they can be effective. Taking a decent video is not a stretch'*** **Louise Chunn, founder of Welldoing**

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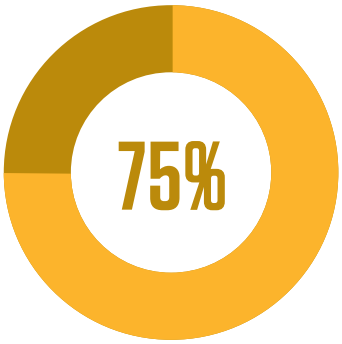
posts about their social anxiety, the celebrity who shares about their panic attacks, the wellness influencer whose business is built on their breakdown and recovery. Vulnerability has become a kind of social currency, signalling authenticity and relatability.

For therapists on social media the implicit message can be that if you want to attract clients you must reveal something of your own struggles. Chunn says therapist directory profiles have changed dramatically since Welldoing was first launched: 'There's much more about the practitioners personally – whether they have children, what they do in their spare time, life and career experience, even that they had a mental health issue or breakdown themselves. Directories are becoming more like dating apps – therapists are definitely more open with personal information.'

Whether such sharing is in the best interests of clients, therapists and the profession is a complex issue, but there is genuine value in challenging the fantasy of the 'perfect therapist', says Hughes: 'When therapists share, carefully and thoughtfully, that they too have had therapy, have struggled, have learned to manage their own difficulties, it can normalise distress and reduce shame.'

## Lifestyle choice

Normalising and reducing shame are also key for Rima Mehta who, along with fellow director Jenny Collard, recently rebranded the service they founded and have run successfully for 14 years, from Rutland House Counselling and Psychotherapy to the Therapy Lounge Collective (**therapyloungecollective.com**), largely in response to what they believe clients want. 'I wanted the brand to feel warm, relational and welcoming – less "you can only come if you are really unwell" and more "this is a place where you can come to feel at




**of people who have had therapy would recommend it***

home, to find some peace and calm, and to work through whatever is troubling you",' says Mehta. 'We deal with very complex presentations and severe distress, but we want the experience of coming to us to feel human, accessible and inclusive. Many clients over the years have spoken about how intimidating it can feel to see GPs and psychiatrists in very medical, clinical environments.'

When clients are assessed they're assigned to one of several 'lounges' spread out over a four-floor building – a corporate lounge for workplace wellbeing, a trauma lounge for deep healing work (EMDR, DID treatment, trauma-informed therapies), a general therapy lounge for broad-range work and couples counselling, and a DBT lounge. Clients can move between lounges as their needs evolve – starting with EMDR to stabilise trauma before moving to DBT skills work, for instance. The model creates what Mehta calls 'a lifestyle place, where you come, do some work, leave when you're feeling ready and then come back when you want to'.

The challenge going forward is balancing human connection with contemporary expectations around speed and convenience. 'Immediacy is part of everyday life now – whether you order on Uber, JustEat or Amazon, you expect and usually get a swift service. Our challenge is managing those expectations in therapy too,' she says. One response is that the practice aims to see new clients within two weeks – consultation within the first week, matched with a therapist by the second. 'It's quick, they're getting help when they need it.'

She admits that the rebrand has felt at times like a leap of faith – not least because they invested in the purchase of the building, bucking the trend for online therapy. 'We're testing what clients want. It's trial and error to work out what they actually end up using versus what they say they want.'

Community is key so the team includes Matt, whose role is to 'keep relationships going – between clients and us as a practice, between us as a practice and therapists who are associates, and relationships with organisations and businesses. There's a lot of communication to think about,' says Mehta.

Rees agrees that clients are drawn to a feeling of belonging to something. Since the pandemic she has used an email list, collected via her website and social media posts, to create a sense of community around her practice, sharing reflections on mental health in the news, practical tips, updates on her work and links to resources. It is not unusual for someone to have read her newsletters for years before reaching out. 'In effect, the therapeutic relationship is starting before they ever walk through the door,' she says.

Younger generations especially feel more comfortable approaching a known entity than an anonymous individual in private practice, says Cariss – one reason why Self Space's marketing feels more like an upmarket health club than a therapy service. 'We live in a brand culture,' she says. 'My long-term aim has always been that Self Space becomes a trusted mental health brand, not just a directory of therapists. We educate, offer community and then, when people are ready, offer therapy too.'

## Therapy on credit

As well as more choice in accessing support, clients are looking for more ways to pay for it. With weekly sessions of £60 and upwards beyond many people's means, it's

***'Whether you order on Uber, JustEat or Amazon, you expect and usually get a swift service. Our challenge is managing those expectations in therapy too'*** **Rima Mehta, Director of Therapy Lounge Collective**

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*'In the past we just had the agony aunt in the back of a magazine and a few self-help books in the library. Now we have this expansive wealth of options'* **Jodie Cariss, founder of Self Space**

becoming the norm for clients to opt for fortnightly or three-weekly sessions to make long-term work affordable. Many therapists also offer discounts for block-booking sessions. Now younger clients are bringing another consumer trend into the therapy room – 'pay in three', an option normalised by the consumer credit company Klarna. 'I've been asked about it by younger clients, and I know some therapists are open to it. I haven't accepted payment by Klarna yet, but there is a credit option available for clients via the online payment provider I use, Stripe,' says Rees. 'It's not something I advertise, but if people ask, we explore it. I think in some cases it's less about not having the money and more about this being how people pay for everything now. A colleague in e-commerce says even low-cost items are often bought in three instalments. It's coming into every area of life.'

The ethical issues are complex, and there are legitimate concerns about encouraging debt. But Rees is clear that financial flexibility is part of the broader consumerisation trend and that therapists cannot pretend it isn't happening. 'More clients are asking for packages where they never would have before,' she says. 'That might mean offering blocks of five or more sessions with a discount. Packages also help with motivation and commitment – if someone commits to a certain number of sessions they're more likely to show up and do the work, which is better for outcomes.'

We've also seen the steady growth of the subscription model in recent years – we can now 'subscribe and save' to household items we need regularly such as pet food and toilet rolls. There are also a host of subscription-basis lifestyle apps marketed to support healthy eating, exercise, meditation and stress reduction. It was only a matter of time before a provider found a way of introducing it to the therapy market, and in 2022 BetterHelp, the controversial US venture capital-funded platform, launched in the UK and offered access to weekly online therapy for £65 per week by direct debit.

Subscription models are harder for lone practitioners or smaller services to operate – although as Rees points out, 'personal trainers have worked on a subscription model for years'. Cariss says it comes down to price: 'To make it viable you'd need to charge £300 a month, more than even the most expensive personal trainers or gyms.'

Self Space is instead about to launch community crowdfund where people can invest anywhere from £25 to £25,000, receiving shares plus perks like newsletters, tote bags or, at higher levels, retreats and therapy sessions. 'I'm interested in what it will bring,' says Cariss. 'I wonder about people – even if they're not able to use the service – thinking "I'm an investor in a mental health brand" and signposting others.'

There is much to be learned by thinking beyond our own profession and learning from other service industries, says Rees. 'There is, understandably, a lot of emphasis on boundaries in our profession, but the more diverse our thinking and professional networks, the stronger and more supported we become. We gain access to more knowledge and skills, and that helps us create a clearer step-by-step pathway for clients rather than letting them fall between services. We can link with other professionals, access peer supervision from different places, upskill ourselves and improve access for clients. That's all part of seeing ourselves as a collective.

'We need to see ourselves as a community of like-minded practitioners supporting people's mental wellbeing rather than a set of individuals. I think we really have to work together, especially as big organisations arrive wanting a slice of the "therapy pie". If you come at it with a collaborative mindset, you naturally attract collaborators.'

## Good therapy

There's no denying that the professional landscape for therapists is turbulent – we're being externally disrupted by tech, by economics and by culture, and we have to respond. The shift from clients to consumers is not merely semantic. It reconfigures expectations and creates a pressure for therapists to not only be clinically competent but also visible, branded and algorithm-friendly.

At the same time, the core of good therapy remains unchanged – people still need to be heard and understood, and they still need a place where their experience can be explored without judgment. The question for all of us is how we can respond to changing client expectations without losing sight of what makes the work meaningful – how do we become more visible in a way that feels comfortable and authentic, adopt useful innovations without losing the quality of the relationship, and respond to therapeutically informed clients without surrendering professional judgment? If we stay open to change while holding on to the therapeutic alliance, we stand the best chance of offering services that are in clients' best interests – and our own. ●

- *For more on how 'therapy speak' is changing both our profession and culture, see our 'Viewpoint' article, 'What in the name of Narcissus is this?' by Julia Bueno, on pages 70-72.*

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ABOUT THE AUTHOR

**Sally Brown MBACP** is a therapist and coach in private practice and a freelance journalist and editor. She writes a free newsletter to support therapists navigating the current professional landscape at **substack.com/@sallybrowntherapy**

# Surviving cancer

**Jenny England** describes the snow dome effect that cancer patients can feel post recovery

According to Macmillan,[1] approximately 420,000 people receive a cancer diagnosis each year in the UK. Earlier screening and diagnosis means an improved outlook and more people surviving than before. But cancer isn't like many other illnesses – even if it clears, the possibility of its return remains, and the awareness of this can be difficult to manage.

A deeper, more present awareness of mortality and the impermanence of life can have a snow dome effect – everything you once knew is shaken up, taking time to settle again, and with some aspects landing in different places. Jill,* in her early 40s, felt a distance growing between herself and her family following the end of cancer treatment. They wanted so much for everything to be all right and return to 'normal', but this left her feeling guilty for not feeling better or wanting to celebrate, and she started to hide her feelings. 'I put on my happy face and pretended everything was fine,' she said. 'They'd supported me for so long, I didn't want to burden them anymore. It's not that I don't want to get back to normal, I just don't know if I can. I don't think I'll ever feel the same again. It's not over for me – I still have some side effects to deal with as well as follow-up scans. Everything's changed; I'm not sure they understand that.'

Jill is just one of many cancer patients I work with, within an NHS Trust centre that offers counselling for those diagnosed with, having treatment for, living with or having survived cancer. As a practitioner, despite my awareness of the very visceral awareness of mortality that cancer survival can leave patients with, I have at times felt tempted to offer reassurance to clients, perhaps overemphasising the importance of hope for the future. I would feel a pull towards wanting clients to feel safe again, to have a break from all the uncertainty.

I now realise the value of (and honesty in) acknowledging uncertainty – being able and willing to share awareness of our vulnerability, of being human, and knowing that at some point each of us will face life coming to an end. In time I've learned how sharing this uncertainty with patients can paradoxically open clients to a deeper connection with life, and in turn bring about huge personal change. Having those conversations has also increased my own awareness of how transient life is. I become more aware of my own anxieties around death and dying, but equally the work has made my connection with the value and joys of life much stronger.

My role is unusual for the NHS. A stand-alone centre for cancer patients was created within the hospital grounds as a result of a local GP who left a legacy for a dedicated space for psychological support for cancer patients. The centre was built with a quiet garden area specifically to provide a refuge and peaceful space for them away from the bright lights and clinical bustle of the main hospital, free of charge. Counselling rooms are carpeted, with armchairs, soft lighting and large windows overlooking trees and hedges. A small, close-knit team offers a warm welcome, and counsellors provide sessions for free, remunerated by the NHS Trust. Anyone in our catchment area and under the Trust, over 18, can be referred by a health professional or refer themselves. Not every NHS Trust gets to have this, but the benefits are huge and I'm grateful to experience it.

***'It's often not until treatment has finished and the initial threat of the diagnosis has passed that the impact of what has happened starts to sink in'***

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## Diagnosis journey

The process for receiving a cancer diagnosis can be slow, following months of trips to the GP and several investigations, or it can be sudden and unexpected. It's a shock whichever way, and it changes everything. Life becomes dominated by hospital appointments, normal routine gets disrupted, plans get altered or put on hold. Medical and personal decisions are made on the client's behalf about what action to take, who to tell, how much to say and when to say it. Life changes not just for the person diagnosed but for those around them.

Going through treatment is often referred to as a 'journey'. This is not a term everyone likes but it does convey something of the length of time it takes going through scans, waiting for results, having treatments, more scans and more waiting for results. Understandably this is a challenging time when most people focus on doing whatever it takes to just get through.

It's often not until treatment has finished and the initial threat of the diagnosis has passed that the impact of what has happened starts to sink in. The brain may have moved into survival mode, protecting from potentially overwhelming feelings of fear. Distance from the threat can enable an optimism, making it easier to cope and get through treatments.

But however hopeful and positive the expectations might have been, you're never really sure how successful the outcome will be until the final results are back and your consultant says you're clear. When I started working in this area I wrongly assumed that clients would feel relief at this moment and even excitement to get back to how life was before, or find new zest for life. I was wrong. I soon found out this was naive and not what many cancer survivors experience at all. Certainly there is gratitude, but for many, surviving cancer is just the beginning of another new and tumultuous journey involving many emotions and complex challenges. The opportunity to have a space to voice those feelings, to feel heard and have a chance to process this was always an important part of the process in clients moving forward and integrating changes.

The truth is, surviving cancer doesn't necessarily eliminate the distress of being diagnosed in the first place. It's often only at the end of treatment, when support feels the least available and when the patient feels the least able to ask for it, that they often need it most.[2] This is also the time when survivor's guilt can set in, where only gratitude and appreciation feel seen as acceptable forms of expression, compounding the difficulty in asking for support.

## Abandonment

Ann,* a retired teacher in her 60s, surprised herself and her consultant by her reaction when he told her he was discharging her. Without thinking she responded by saying, 'Are you finishing with me?' Catching the look of shock on his face she quickly made out she was joking and laughed it off. Later, when reflecting over her reaction, she likened the intensity of her feeling to how she might have felt if a partner suddenly ended a relationship.

'I think he forgets; I may be one of many patients to him but he is the only consultant I have. I hang on every word he says, study his face, try to work out what he's going to say. I think a lot about preparing the questions I need to ask when we meet.' It wasn't only her consultant who generated these feelings. 'I had all these people caring for me,

helping me through one of the scariest times of my life, then it just stopped. It was like being on a conveyor belt and just dropping off the end. I missed the support and reassurance from the nurses and doctors.'

Unlike many illnesses cancer can mean being a patient for several months or years. At one of the most vulnerable times of your life connections are made with the doctors and nurses who help you make key decisions, and these can become important and intense. There is a trust placed in professionals to guide you through as you 'put your life in their hands'.

Although treatments for cancer are demanding, they can be reassuring, knowing that something is being done, providing, to some degree, a sense of having some control. When treatment comes to an end all of that suddenly stops. As in the case of Ann, there can be a sudden sense of loss, like having a safety blanket taken away.

This extends beyond just health professionals. Family and friends may have stepped up, putting their own needs on hold in order to give more support. But when the treatment ends they might return to the activities and responsibilities they set aside. This sudden change in the level of support they are offering can also unintentionally increase a sense of abandonment for the person who's survived, and can lead to feelings of guilt for wanting, or still needing, support.

## Invisible change

It's easy to remember someone might need support when there is a visual prompt, such as a plaster cast, scar or other obvious change in appearance. But less visible changes can be hard to remember when a part of the body has been removed, internally or externally, or treatment has resulted in an addition to the body, like a stoma, feeding tube or artificial voice box. Some changes permanently alter how the body functions. Side effects such as neuropathy (a nerve problem that can cause swelling, tingling and numbness, often in the feet), fatigue and brain fog, along with general aches and pains, can continue long after treatment stops, again making it difficult to feel it is over.

*'A degree of dissociation can be helpful in managing fear, but once the threat to life has passed, feelings held at bay may start to arise'*

Additional pressures around physical intimacy can start to impact relationships as expectations start to change. The whole experience alongside changes to your body can affect how attractive you feel and directly impact on sexual desire and function.

Survivors can also lose trust in their body. Unconsciously there can be an expectation that if we had something as serious as cancer we'd be aware of it, that there would be some kind of sign, indicating something was wrong. This isn't always the case. Cancer can be discovered by chance, with no symptoms, at a routine check-up. When this happens it can be particularly difficult to trust your body in the future. The thought that cancer can be present without you knowing it can make it feel like an ever-present danger, intensifying fears of recurrence.

## Traumatic

The *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5-TR*)[3] includes diagnosis with a life-threatening illness such as cancer as a potentially traumatic event. Regardless of the outcome, the experience of receiving a cancer diagnosis generates fear and anxiety about whether you'll survive.

Many clients recall a level of dissociation when they are first told they have cancer – often describing feeling numb, or having a sense of being outside their body, as if they are watching a movie of it happening to someone else. This form of distancing can, as trauma expert Peter Levine describes, 'help to make the unbearable, bearable'.[4] A degree of dissociation can be helpful in managing fear, but once the threat to life has passed, feelings held at bay may start to arise.

Psychologist Karen Treisman[5] describes the moment of diagnosis as being a potential 'medical trauma'. She notes how previous trauma/s can be triggered by examinations, scans and treatments, adding to a person's distress at the time. It might not be a specific moment that stimulates a trauma response – it can be the 'imprint left by the wider experience on the mind, brain and body'.[6] Hospital follow-up appointments can act as triggers and generate a rise in anxiety.

Feelings of immortality are shattered.[7] Any beliefs that life is fair, secure and predictable get challenged. A fear of dying doesn't necessarily disappear because you survive. Yalom points out that the experience can act as a catalyst for an 'awakening experience' prompting fear and gratitude.[8] Placing the attention on gratitude alone can not only minimise a person's full experience but be a missed opportunity to explore the experience more deeply. For some clients being allowed to have this process of reflection has led them to make significant lifestyle changes. Some clients refer to life after surviving cancer as their 'second life'.

## Relationship changes

Cath,* a grandmother in her 60s, started to re-evaluate how she spent her time. Reflecting on her role as a mother and grandmother she decided she wanted more balance between offering care to her family and caring for herself. 'I used to look after my grandchildren whenever I was asked. My daughter would just ring me any time and ask me to look after her two children, and I'd drop whatever I was doing. Don't get me wrong, I love my grandchildren, but I'm not as young as I was. I used to get exhausted and often missed out on seeing my friends. I still look after them but now I make time for me too. It wasn't easy saying no but I think I needed to. I never used to think about "time" before all this, but it's made

me aware how quickly everything can change, and how fast life can go.'

Time away from normal routines and responsibilities creates time to reflect on personal values and priorities. It can bring a focus on how quickly life can alter, how short it might be, and can change a person's perspectives.

Laura,* in her 30s, was surprised by the impact surviving cancer had on her relationship with her partner. They'd previously shared a similar approach to parenting, finances and time management. Post cancer Laura noticed herself taking a 'live for the moment' approach to life: 'I don't want to wait around and put off doing things. What if it comes back? I might not be so lucky next time.' She became more impulsive, booking extra holidays and spending more on presents for their children. This started to cause tension between her and her partner, who had a different reaction. During her illness he'd stayed positive for her but hid his fear of losing her. He wondered how he'd cope if he was left on his own with their children. He became more focused on saving as much he could, wanting to build more financial security. Sharing their experiences together and understanding the different impacts the cancer had on them opened conversations to finding a balance they were both more comfortable with.

## Reoccurrence fears

The fear of cancer returning is common. Ferrell et al reported significant levels of anxiety and fear in women post breast cancer around their cancer returning.[9] Higher levels of anxiety are often accompanied by hypervigilance, when we stay on 'red alert', constantly scanning our body, amplifying any ache or pain, in an attempt not to miss any signs of cancer being back. The potential exhaustion and distress experienced with hypervigilance make it difficult to enjoy ordinary pleasures and reach a sense of relaxation. The brain needs to turn off its natural vigilance in order to relax.[6] Some of my own clients have reported feeling overwhelmed when their mind is focusing in this way so much of the time. With the constant anxiety and worry, and feeling continually under threat, there can be an urge to 'run away' and escape. This can show up as a need to keep constantly busy and distracted, potentially causing a self-perpetuating loop and exhaustion. Living with the fear of recurrence can also generate feelings of envy towards family and friends who are free from these fears.

## Confidence loss

It can be several months or over a year from the point of diagnosis to the end of treatment. During this time there might be a need to step back from or adapt any roles and responsibilities such as being a parent, partner, carer or colleague etc. These roles often connect to our identity and sense of self, but when they are altered due to circumstances beyond our control, our self-confidence and self-esteem can be affected.

Returning to work can also bring challenges, even in a supportive environment. The experience of being away from work may have altered how you feel about it. Structures and colleagues may have changed. The way colleagues treat you may be different. Carol* had worked her way up the company over several years and was leading and managing a team before she was diagnosed with cancer and needed to take a year out for treatment and recovery. Her phased return to work had been planned and worked well – however, she was frustrated by the fatigue and difficulty she still felt with her concentration levels. Before she was off she knew others saw her as confident and competent – someone colleagues would turn to for support and advice. When she returned, however, she described how 'some of the team would give me this look, like they feel sorry for me, or don't know what to say. I know they mean well but I want to be treated the same. I'm still capable, I can still be someone who can support others, listen and give advice, I'm still Carol. I don't want cancer to define me; to change the way people are with me.'

## Continually learning

The experience of surviving cancer isn't the same for everyone, but one commonality is that focusing only on the gratitude of survival can deny other feelings that can be valuable to explore. While gratitude, hope and positivity are valuable, they ought never to be at the exclusion of acknowledging fear, sadness and any other losses that may have been part of the experience. Fears can rush in like tides when scans are due, or recede as results are back and clear. Supporting clients in allowing these waves can be powerful in helping them to find a balance between acknowledging fears and not letting them dominate life as it continues. For some this is a long-term process, but we have the tools to hold them as they take the time they need. ●

**Client case studies are fictionalised and based on typical examples.*

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# Resocialising motherhood

**Helen Davies** explores how psychotherapy supports transitions and motherhood

Looking back, I don't think it's a coincidence that my becoming a psychotherapist coincided with my becoming a mother. Something had shifted within me since having children. My world view, my priorities, my values, my relationships, my politics and my existential considerations all altered. I was thrown into motherhood and suddenly thrown out of everything else I'd known. As, over time, I matured as a mother (and psychotherapist), I re-established some continuity of self, and the chaos and confusion gave way to growth, but resentment simmered. Not towards my babies, or to the work of being a mother, but towards a world I felt had left me unprepared and unsupported in this new motherhood. There had been no books, theories or experts providing an anchor to tether to during my existential labourings, there were no whispers at baby groups, there were no words offered to make sense of it. I knew motherhood had irreversibly changed me, but I doubted myself, because if it was real, why wasn't it talked about, and where was everyone else?

Currently there is little within perinatal mental health (PNMH) care that considers what happens when a new mother enters the world. The cornerstone of PNMH is developmental-relational psychology, whereby the 'good enough' primary care giver (mostly mothers) acts as the secure base from which a child must develop their sense of self.[1] The mother's condition is therefore only considered in relation to the impact on their child, meaning mothers are born into a world where they are the 'object' and not the 'subject' of their own experiencing.

As I wrestled with psychotherapeutic theory, practice and my own maternal becoming, I became acutely aware of the conflicts, pressures and tensions the overt and covert demands on mothers engendered. To be stable and secure while also transforming. To simultaneously discount and prize self. Rarely during early motherhood did my 'hierarchy of needs'[2] and 'ego state'[3] accord with the criteria given for a 'healthy self-concept'.

These messages left me confused, overwhelmed and painfully ashamed. I doubted myself; was I doing it wrong? Was I abnormal? Was I selfish? Could I be harmful?

## Matrescence matters

Coined by anthropologist Dana Raphael in the 1970s, matrescence describes the major physical, social, psychological, economic and spiritual transitions new mothers experience. Matrescence is understood to be a unique time of change in a person's life. At the same time, lack of public recognition made it feel like a nonsense, undermining what I had inherently known. It struck me that by not openly recognising maternal existential experiences beyond pathology (for example, perinatal mood and anxiety disorders) or the infantilising 'baby blues', the suggestion is that having a baby is of little consequence to an individual.

It also seemed lacking that psychotherapy could simultaneously hold 'self' and the singular importance of primary caregivers to developing humans in such high regard, and yet neglect to consider individual mothers within the context of motherhood. My frustration with this oversight resulted in my researching the lived experience of matrescence.[4]

The aim of my study was to understand matrescence from a psychotherapeutic perspective by exploring the lived experiences of different mothers during early matrescence (six to 12 months postpartum). The findings of this study, supported by the wider literature, shed light on the experience of matrescence as one of change within all existential dimensions. New mothers experienced an interrelated and intersubjective process of becoming, fraught with existential confrontations. Emotional flux and paradoxical 'all at once' feelings left mothers experiencing unpredictability and dysregulation at a time when they felt the requirement and expectation to be stable, solid and secure. Identity, existential and relational shifts, such as mattering both more and less, encountering their own morbidity and the reconfiguration of all inter- and intra-relationships, added to the feelings of chaos. Matrescence was encountered as an intense, turbulent and chaotic emotional and identity experience. While it had huge potential for growth and opening up of self, it was destabilising and further impacted by these hard experiences not meeting high expectations.

The impact of personal and societal expectations on mothers' experiences cannot be overstated. The dominant cultural discourse suggests motherhood will be a time of joy and fulfilment, and yet it omits to share that it is also a time of significant personal change, challenge and potential distress. Currently suicide is the leading direct cause of death for mothers up to 12 months after the end of pregnancy.[5] Almost a quarter of all deaths during pregnancy and up to a year postpartum are caused by mental

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health-related issues, while over a quarter (27%) of all new and expectant mums are affected by 'perinatal mental conditions' in England. It is likely those figures are far higher given the barriers to voicing maternal mental health concerns.[6] These figures alone suggest that the psychological experience of becoming a mum is as 'typical' and inherently challenging as the physical, yet little proactive guidance is given. Support is generally only pre-emptively offered in cases of prior health concerns or those considered 'atypical', such as adoptive. This paucity of proactive information and support can create stigma that serves to silence real experiences of motherhood while inadvertently upholding idealised notions. This may leave mothers shocked and othered by their own mothering experiences.[4]

We are hardwired for connection and so feeling that we don't belong can have a detrimental effect on our mental health.[7] By openly acknowledging that mothers can be emotionally and existentially impacted by becoming a mother, and considering how, could be hugely beneficial to a mother's wellbeing, supporting them to feel safe and secure within their intrinsically insecure novel experiences. By recognising the challenges and confrontations matrescence poses, the hope is that distress is no longer considered a deficit in the mother, or an illness (without minimising that responses can be severe and debilitating), but a fundamental experience of new motherhood. Through conceptualising this major life transition, psychotherapists and healthcare professionals are more able to provide guidance and support to mothers and their families and commence the redress of the dominant discourse.

## Psychoeducation

Better understanding of maternal transitional and identity process experiences certainly brought benefit to my personal understanding and individual client work, but I felt more was needed. Change also has to happen outside the therapy room. A different socialisation of mothers is required, with open and shared dialogues about what is *actually* experienced when someone becomes a mother. I wondered how mothers might experience themselves and motherhood differently if that were the case. What could change if a supportive environment where mothers felt validated, respected and listened to was proactively offered, not just reactively?

I took my thoughts around the sharing of psychoeducation and peer-to-peer experiences, and my hopes of creating a mother-centric space, to my then mentors at the Parenting Project (**parentingproject.org.uk**), a charity supporting parents and families with counselling and advocacy. I was lucky enough that it shared my belief and passion and had the resources to support the development of a pilot programme. In September 2024 we launched Project Matrescence, a therapeutically informed group programme for new mothers. A six-week circle, Project Matrescence invites mothers to connect with self and with other mothers and creatively explore their personal and shared experiences of matrescence. Each week considers a different theme, such as identity, emotions, relationships, births and endings, and uses creative therapeutic techniques and tools such as clay work, haikus, non-dominant hand drawings, life narratives and collage to support individual expression.

As childcare can be a barrier to accessing individual support, a crèche was provided within a connected but separate space. We carefully considered the implications around attachment (baby-to-mother and mother-to-baby) and decided that we wanted to provide a different space for individual mothers – one that also allowed them to share 'other to mother' parts of themselves. This decision was well received by participants who felt we had provided a space 'to voice themselves completely' (Nina).* The crèche was seen as 'vital' (Beth)* taking 'so much stress out of attending and was a nice way to ease [us] into a childcare

environment. I could not have attended if it didn't exist.' 'It was fantastic, so engaging and really supported us as mums and the babies too.' (Katia.)*

## Unconscious process

We raised awareness of the pilot through children's centres, churches, playgroups, nurseries, libraries and coffee shops in the local area. We were also able to connect with health visitors and midwives through the already established Parenting Project network. We invested time in social media, connecting with appropriate local businesses, influencers and parenting groups.

Mothers, including non-birth mothers, around six to 12 months after the arrival of their first child were invited to participate. Mindful that matrescence is a unique time of physical and psychological transition, and that emotional states can be heightened during this life phase, we anticipated that it might evoke difficult or uncomfortable feelings. Particular consideration was given to the exploration of unconscious process through the creative process and relational processes within the group. Holding in mind BACP's *Ethical Framework*,[8] particularly the ethical practices of beneficence and non-maleficence, we established a series of safeguarding systems including a screening process. A pre-booking consultation provided an opportunity for all parties to share information and to consider whether Project Matrescence would be a supportive space for them. Where risk might be a concern, signposting towards and provision of additional supports including one-to-one counselling through the Parenting Project were put in place. Working agreements were shared verbally and over email covering risk, confidentiality and limitations.

Our pilot was facilitated by two BACP and UKCP accredited integrative psychotherapists; me and Paula Tebay.

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We used a local community centre, and each week aimed to create a reflective, inspiring, warm and nurturing space, resourcing it with seasonal objects, a variety of art materials, the latest literature and nourishing homemade bakes. Each session lasted 90 minutes and established a consistent ebb and flow; time for mothers to 'arrive'; group welcome and reflections; theme and psychoeducation presented; time for each theme to be individually and creatively explored; opportunity for small and large group discussion; ending with a grounding and relaxation exercise. Time either side of this was provided to support mothers and babies entering and exiting the crèche space.

## Establishing outcomes

The monitoring of outcomes and processes was felt to help in the detection of problems, decrease negative outcomes and boost therapeutic gain[9] while also supporting our intention to pursue future funding. As no adequate single model existed to measure the experiences of new mothers, a bespoke qualitative and quantitative outcome measurement tool was created. Consents for information to be gathered, stored and anonymously shared were explored and agreed.

Out of a possible 10 spaces, seven participants attended our initial pilot group. All were cis-female, aged between 30 and 45 years and from white-British, Asian-British and white-European backgrounds. All were first-time mothers of babies aged between six and 13 months old. The following composite case studies are taken from the initial pilot and subsequent groups to preserve confidentiality.

## Beth

Beth was flooded with emotion during the initial consultation. She expressed feeling shocked and concerned by emotions and feelings she hadn't anticipated. In addition to the labour of her new caregiving responsibilities, these emotions left her feeling overwhelmed, vulnerable and isolated. We explored her current support structures and considered what might be beneficial. She hoped the group would be a space for her to meet other mothers who might feel the same.

Beth shared some of her difficult thoughts and feelings within the group and reflected on the immediate shame and guilt she had felt in doing so. This quite quickly gave way to relief and validation as others within the group shared similar experiences. Beth's vulnerability was received gratefully by other group members, held and praised as the vanguard to voicing their own fears. In this Beth articulated a change in her perception of her self witnessing her own strength and courage.

Throughout the weeks Beth worked on acknowledging and processing her emotional states. She immersed herself in the creative tasks. Often they would not have a static start or end point but continually evolved, being worked and then reworked. In this Beth noticed how she was 'stretching', 'transitioning' and 'reshaping', while also recognising where ruptures had occurred. Beth used the art materials to mentalise her feelings around the ruptures – 'pain', 'loss' and 'rage' – beginning to put images and words to some of what she needed: 'nourishment', 'containment', 'honesty', 'care'. She also recognised how guilt and shame held her back from receiving those. Again by acknowledging her wounds Beth was able to witness her strength, ending the programme with expressions of growth and empowerment. In her review Beth felt the group had hugely benefitted her ability 'to be', allowing her to feel 'justified in [her] struggles, feelings, highs and lows... coming away with a new perspective'.

***'The provision of a safe and supportive environment allowed mothers to feel confident in sharing their differences, trusting that they were cared for and accepted'***

## Nina

The initial call with Nina had been difficult to arrange, appropriate time had been scarce and we had a couple of false starts. Nina loved being a mother but was lonely and scared she wasn't capable of being good enough. Nina juggled work responsibilities alongside childcare, which left little time or space for herself or her previous relationships, resulting in feelings of inadequacy and ambivalence as she struggled to keep up with demands. She was disappointed with, and at times resentful of, the lack of support she had received. At the same time she acknowledged she struggled to ask for support.

Nina took pride in her creative expressions, enjoying the messages and metaphors of growth, healing and connection they reflected to her. Each week we would end by inviting individuals to offer a word of reflection back to the group. Nina's words were often a recognition of validation, togetherness, connection, gratitude and love. The dedicated space for her and shared group experiences seemed to fortify Nina to take up space outside the group. She felt able to make requests and set new boundaries, which were reassuringly supported by her outside network. Nina reflected that she had found the group to be 'a life-changing experience full of support and love' and that her 'connection with the group' had helped build her connection to, and confidence in, her voice as a mother and as an individual.

## Katia

Katia had expressed that she had felt at her lowest in the weeks after birth. She had found it difficult to bond with her baby, and this left her feeling inadequate, guilty and anxious about the impact on her child. Katia rated how well she was doing in terms of personal and interpersonal wellbeing as a '1' on a scale of '0' (being the lowest rating) to '10' (being the highest). We took time to consider her needs and risk and the limitations of the group, and considered what might be supportive. She expressed a desire to be with other mothers and to talk about their experiences. She experienced other mother-baby spaces as ones where only surface-level conversations were possible and therefore barriers to reaching any depth or recognition of difficult or unexpected experiences.

Throughout the sessions Katia reflected how busy she had been and how many pressures she had been under to maintain everything she had before having a baby. She recognised how this 'doing' had taken her away from 'being', and through the creative exercises noticed how small and hidden her 'self' had become. In allowing herself to voice her difficulties and receive support and validation Katia experienced significant relief. With the anxiety that she had been 'doing it wrong' lifted, she was more able to recognise and validate the power of the love and connection she had with her baby.

'It has made me a better person and mother, for myself, my baby and my family. An experience I will positively carry for life... this group has saved my mental health.' In her review Katia recorded a considerable increase in her own sense of wellbeing, now scoring 7 out of 10.

## Future groups

One of the major themes I took from this feedback was the power of collective care and its ability to engender healing and growth. Unlike individual therapy, sharing experiences with others who may be having similar experiences at the same time seemed to actively reduce feelings of isolation and failure that may compound an already challenging time. The provision of a safe and supportive environment allowed mothers to feel confident in sharing their differences, trusting that they were cared for and accepted. This seemed to provide relief from the anxiety they were 'doing it wrong' and supported the development of trust in their own mothering experiences. This provided a strengthened and empowered base, which further reduced feelings of distress.

The pilot project was considered a success with all participants reporting that they felt heard, understood and respected, and that the goals, topics, approach and methods were relevant and that they would recommend it to others. This feedback enabled us to secure three years of investment from the Parenting Project to roll Project Matrescence out across the whole of Warwickshire. Project Matrescence aims to run six groups annually and for free in locations including Kenilworth, Stratford, Rugby, Nuneaton, Bedworth, Leamington Spa and Warwick until at least 2028. Our first 2025 group was fully subscribed, with a waiting list for future groups. The hope is that this programme can be launched nationally – connecting, supporting and nurturing mothers and re-establishing motherhood.

**All names have been changed.*


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## ABOUT THE AUTHOR

**Helen Davies MBACP, UKCP** is an integrative psychotherapist working in private practice in Warwickshire. Her research in matrescence has led to the development of Project Matrescence – a psychotherapeutically informed support group programme for new mothers. Instagram **@project.matrescence**; **projectmatrescence.org**

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# ‘A holistic approach gave me the courage to heal gently’

Someone once told me that burnout isn’t like a fire alarm going off – it’s more like a carbon monoxide leak: silent and invisible, you don’t realise it’s happening until you are already gasping for air. That’s exactly how it was for me. I kept functioning, kept coping, until I couldn’t.

Burnout crept up after years of personal and professional strain. I lost my sister, a dedicated NHS nurse, to lung cancer during the pandemic. The day before she died, my eldest daughter went into premature labour and delivered a healthy baby girl by C-section. My sister was already very unwell. We waited 10 hours for an ambulance that never came, and by the time we reached hospital she was fading fast. A photo of the new baby arrived, and we cried tears of joy and sadness. She slipped into a coma soon after and died. We had both been supporting my brother, who lives with psychosis, a responsibility we had taken on when our parents passed. My sister’s death left a huge gap, not just in my life but in the wider family support network.

I took some time off, organised her funeral, then went back to seeing clients online and later from home. Looking back I see how many layers of loss I was already carrying. I felt exhausted but couldn’t name why. I’d been struggling with tinnitus since 2019, and after years of being dismissed by healthcare professionals I was finally diagnosed with Ménière’s disease, a condition affecting balance and hearing.

Then in July 2023 my 21-month-old granddaughter was diagnosed with leukaemia. It felt like a scene from *Mary Poppins Returns* where cousin Topsy declares, ‘It’s the second Wednesday!’ and her whole world turns upside down. Everything familiar was still there but completely disorientating. That’s exactly how my inner world felt. I was standing in my life, but emotionally everything had flipped on its head.

I didn’t follow a single path back to balance – I followed a holistic one. I continued supervision while taking a break from clients, giving myself space to process emotions safely and reflect on my future. I worked with a coach for three months, had short-term counselling and even tried emotional freedom technique tapping. I attended compassion and mindfulness workshops, studied facilitation and supervision, and slowly began developing my own workshop on self-compassion. While therapy played an important part in my recovery, it was the combination of counselling, supervision and coaching, each offering a different kind of space for reflection and growth, that supported my healing.

I spent restorative weekends on the coast with friends and listened to podcasts about burnout and compassion fatigue. Reading Paul Gilbert’s *The Compassionate Mind* helped me soften my inner critic and treat myself with gentle kindness. At one point I even considered retraining as a death doula (a non-medical support person), searching for ways to bring meaning to what I’d been through.

This combination of support gradually restored my clarity and confidence. Supervision and therapy helped me process the shame I’d felt about ending with clients so abruptly, while coaching gave me practical tools to rebuild structure and direction. Retreats, reading and reflection reminded me that rest wasn’t failure, it was care.

Small, consistent practices made the biggest difference: pausing to notice my emotional state, journalling, mindful walks by the sea, observing the changing seasons. Setting boundaries protected my energy and allowed me to return to client work gently, starting with just one client at first.

By February 2025 I finally felt ready for something new. I travelled to Vietnam and Cambodia for three weeks with a close counselling friend. Immersing myself in Buddhist ideas of acceptance and forgiveness deepened my healing and helped me see that gentleness and surrender can be forms of strength. Then, in August 2025, my granddaughter rang the bell to mark the end of her chemotherapy. That joyful sound, bright and defiant, felt like a new beginning for all of us.

Recovering from burnout wasn’t a straight path, but embracing a compassionate, holistic approach helped me rediscover balance and purpose. Support can come in many forms: supervision, counselling, coaching, retreats or simply moments of kindness towards yourself. Stepping back, caring for yourself and allowing gentleness can transform not only how we work but how we live. For me that’s the courage to be gentle, and it truly changed my life.

NEW AFRICA/SHUTTERSTOCK


## ABOUT THE AUTHOR

**Alison Huckle BACP** is an integrative counsellor, supervisor and facilitator with a special interest in self-compassion, supporting counsellors through burnout and compassion fatigue recovery. She runs ‘The courage to be gentle’ workshop, helping practitioners explore gentleness, sustainability and compassionate practice.

# ARE BRIEF CLIENT NOTES ENOUGH?

**Q** **I've been working as a therapist for several years and my notetaking process has evolved during that time. I used to take detailed notes but now I only jot down the briefest of bullet points after each client session. Once a month before supervision I write a reflective summary of how the work is going with each client, pulling out any themes and important developments that I want to discuss. This works for me, and so far I haven't forgotten anything important, but could there be potential consequences in the future of not recording detailed notes after every session?**

**A**

Early in my personal therapy, I remember feeling surprised and moved when my therapist offered a reflection that showed she remembered a small, seemingly random detail from a previous session. I felt properly listened to, and it was then that I began to believe that what I was saying mattered to her.

Retaining what we hear in sessions is pivotal in helping us develop a relationship of trust with our clients. Many of us prefer the reassurance of making notes of key details rather than relying on memory, particularly when we have a busy practice.

You don't share your reasons for changing your notetaking practice, but for many practitioners there is a tension between recording enough to support the relational aspect of their work while also complying with the *Ethical Framework* (*EF*) recommendation to 'keep accurate records that are adequate, relevant and *limited to what is necessary* for the service being provided' (my italics) (Good Practice, point 15).

There has been raised awareness of the ethical and legal responsibilities associated with collecting, storing and sharing personal information since the Data Protection Act was introduced in 2018, followed by the UK General Data Protection Regulation (UK-GDPR) in 2021. This legislation means that most practitioners now need to register with the Information Commissioner's Office as a 'data controller' (to check if you are exempt, see **ico.org.uk/for-organisations/data-protection-fee/data-protection-fee-self-assessment**). We must also be mindful of what we write in client notes, ensuring that only relevant and necessary information is documented, and that it is stored securely in accordance with GDPR standards. This heightened awareness reflects a broader cultural move towards transparency, accountability and respect for the individual's right to privacy – values that align with our profession's own ethical principles.

**The opening response to this dilemma reflects typical points, questions and issues that may be raised if the dilemma was brought to the BACP Ethics team. This includes highlighting all the potential implications of a dilemma, including those that the practitioner may not have considered or asked for specific advice on. Following this response, *Therapy Today* readers share insights based on their own experiences.**

## Adequate notes

If bullet point session notes work for you there is no need to discard this approach, but it's worth ensuring there is consistency and a system to these points. For many practitioners the easiest way to do this is to create or use an existing proforma document to serve as a prompt for what is recorded. According to *Practical aspects of record keeping within the counselling professions* (GPiA 067), notes should record:

- a summary of what was said by the client and directly observed by the practitioner
- a record of the practitioner's intervention, strategy and any action taken plus a note of the reasoning behind this
- attendance or non-attendance and session number.

Different therapeutic approaches and contexts may require different recording styles, but all notes should be written in a 'professional manner' and 'contain commonplace words', with sensitivity towards language in relation to equality, diversity and inclusion, using terms that are considered to be acceptable by individuals within the demographic groups being referred to (relevant CPD may help support you in doing this).

Whatever approach you take, clients need to give informed consent for notes to be kept, which means that you will need to include in your written contract, and ideally also discuss verbally in an initial session, what notes you make, how you will keep them, who else may have access to them (such as your supervisor and the trusted colleague nominated in your clinical will) and how long you will keep them for.

RIFTA DEWI/SHUTTERSTOCK

## Evolution

I think it's always worth paying attention to any change in behaviour, as human patterns seldom shift without reason – even small deviations may signal evolving needs, emerging pressures or areas of growth. By observing these changes with curiosity rather than judgment we may gain insight into what has altered and why it may have done so.

As your career has matured, so it seems has your notetaking practice, which is not unusual – the 'back office' of practice is an ever-evolving process for many of us. You say you used to take detailed notes but now only jot down the briefest of bullet points after each client session. I'm curious about what you classed as 'detailed notes' and how they differ from your current notes – for instance, what did you choose to leave out? It's also worth reflecting in supervision on when and why this change began, to help you understand what it may reflect about you and your practice.

The change may signal growing confidence in your skills and abilities as a practitioner, and a recognition that you can let go of the 'prop' that detailed notetaking can provide. I also wonder if the evolution of your approach has been influenced by the wider cultural shift in attitude towards keeping sensitive information? Perhaps unconsciously you have moved to a system where you keep the type of notes you would be comfortable being made public by a subject access request (the right of an individual to request a copy of all personal data held about them, including therapy notes), or if required as part of criminal justice proceedings (as discussed in 'Your notes, your rights', in *Therapy Today*, December 2025/January 2026).

It could, however, also suggest you feel overwhelmed – or bored – by some aspects of your practice such as the administrative tasks, and are trying to find ways to make your workload feel less onerous. The growth of AI-enabled notetaking software packages aimed at medical and therapeutic professionals – often advertised with a 'don't you hate notetaking/doesn't it take too much time when you could be doing something more useful?' approach – suggests you're not alone. If you're considering using AI you need to be confident that you understand how the data are used and kept, and how they comply with our confidentiality and GDPR requirements. You also need to gain clients' informed consent and include your use in your written contract (Good Practice, point 26).

Viewing notetaking as just an admin task, or something we have to do to be 'good therapists', overlooks its therapeutic value. Done well, it can be a vital and active part of our work. I wonder if the doubts you have about your system suggest that on some level you recognise that the reason for the change wasn't a positive one. If this is the case, then it may be time for a review of your practice, including your caseload and working hours, to ensure you are not overstretched (or alternatively, understimulated) and undermining your wellbeing.

## Confidentiality

Your dilemma raises two separate but equally important points – is your system complying with your obligation to keep client records confidential, and is it fully supporting your practice (Our commitment to clients, point 2e)?

Let's start with confidentiality. Client records include your session notes and also data such as the contract made with clients, copies of referrals or correspondence with other professionals written and received, dates and times of sessions, assessment and intake documents, outcome measures and risk assessments, email correspondence with the client and details of fees paid. You don't give any details about how you store these records, but more of us are choosing to use practice management software such as Bacpac or WriteUpp to do this because they offer a high level of security. It may be that you are using such software to store your bullet point notes along with other client records. It is also possible to use a non-commercial or paid-for system to do this instead by, for example, using password-protected Word or Google files stored on a password-protected device.

You say you record your more in-depth reflections separately and, although you don't say how, I am imagining this is a personal journal. These types of reflections can form a key part of reflective practice. Having a regular process for reflection is important for all practitioners who use 'self as tool' in their work, not least for their own self-care and to monitor how the work is affecting them but also to remain aware of how their own preconceptions and biases may be colouring their approach, or when there are knowledge or skills gaps that need addressing. As well as supporting your supervision, it seems that these reflective summaries are serving this purpose for you.

However, as Karen Stainsby points out in *Confidentiality and record keeping within the counselling professions* (GPiA 065),

such reflective journalling, along with 'notes made in preparation for, during and after supervision, where a client is discussed' should be regarded as a record and stored securely, even if they don't include any identifiable details of clients. As she puts it, this even includes 'a practitioner's personal reflections about a client that are scribbled down on a scrap of paper'.

It's important to assess whether you are meeting the minimum requirement for confidentiality both in what you record in these notes, including whether you are fully confident that no details of any individuals mentioned are identifiable (such notes must be 'thoroughly anonymised', Good Practice, point 55g), and how you store them.

This does not necessarily mean changing your system. Many people enjoy journalling longhand in a physical notebook and find it aids the reflective process. If this is important to you, it would be a shame to let go of it, so perhaps the question is one of storage. Could you consider keeping these notes in a locked drawer or filing cabinet at home (if you don't already do so)? If you have supervision in person and take your notebook with you, are you confident that no clients could be identified should you lose the notebook on the way, and it was found and read by someone (perhaps a good point to discuss in supervision)?

*'Memory is reconstructive, not reproductive – we don't recognise what we've forgotten because the gaps fill in seamlessly'*

Now let's look at whether your system is fully supporting your practice.

## Is your system working?

In terms of the relational process and recalling details, you note that you 'haven't forgotten anything important', but you question whether there may be 'potential consequences' you have overlooked. As Madi Ruby reminds us in *What do we mean by records and record keeping within the counselling professions?* (GPiA 066), while the *EF* is not 'prescriptive as to the format of records... as a BACP member, you will need to be accountable, and able to show clear ethical decision making in respect of any records that you keep (or do not keep).'

Part of this ethical decision making should include the broader purposes that notetaking serves beyond supporting factual recall, or preparing for supervision, as follows:

**Continuity:** Client notes help us track the trajectory of work, notice patterns over time and maintain continuity if sessions are interrupted by holidays or illness. Reflective summaries may capture broad themes, but can you ensure you also hold in mind details of session-by-session developments that can be therapeutically significant?

**Supervision:** Reviewing our work with clients in supervision is part of our commitment to demonstrate 'accountability and candour' (Our commitment to clients, point 6c). For most practitioners their client notes play a key role in informing supervisory discussions.

Writing reflective summaries before supervision sounds like an effective way to prepare, creating an opportunity to pause, pay quality attention to your practice and think about any themes, patterns or concerns you would like to raise with your supervisor. There may be a chance, however, that thoughts or concerns throughout the month that aren't recorded at the time are omitted from your pre-supervision reflective summary as they are no longer front of mind. Could you experiment with a more regular reflective process, perhaps adding to it weekly, to see if this makes a difference?

**Client welfare:** Will a reflective summary capture the subtle warning signs or session-by-session shifts in clients who become suicidal or require a referral for specialist mental health support? Any session involving risk assessment, safeguarding concerns or significant clinical decisions requires detailed notes taken as close to the session as possible, regardless of your usual practice. It may be that you already expand on your brief bullet points when issues that concern you are raised in a session, but if not, could you consider doing this?

**Personal protection:** Records may be requested in professional conduct proceedings if a client makes a complaint, or in legal proceedings or safeguarding investigations. In these contexts you may need to demonstrate exactly what was discussed, when concerns were raised and what actions were taken. Will your

## SUPPORT AND RESOURCES

**You can find more information in the following BACP Good Practice in Action resources, available online at bacp.co.uk/gpia**

- *Confidentiality and record keeping within the counselling professions* (**GPiA 065**)
- *What do we mean by records and record keeping within the counselling professions?* (**GPiA 066**)
- *Practical aspects of record keeping within the counselling professions* (**GPiA 067**)
- *Sharing records with clients, legal professionals and the courts in the context of the counselling professions* (**GPiA 069**)
- *Ownership and storage of client notes and records in the context of the counselling professions* (**GPiA 071**)
- *The United Kingdom General Data Protection Regulation (UK-GDPR) legal principles and practice notes for the counselling professions* (**GPiA 105**)

bullet point notes and reflective summaries provide enough support for you to be able to do that? Consider a scenario where a client makes a complaint about something that occurred in a specific session several months earlier. Your bullet points from that session may be too sparse to provide meaningful detail, and your reflective summary may not reference that particular session at all if it didn't seem thematically significant at the time. You would then be relying entirely on memory to defend your practice, potentially many months or even years after the event. This is another argument for a more flexible approach and switching to more detailed notes when needed.

**Professional accountability:** Under the UK-GDPR, clients have the right to access all data that relate to them. Although you may not consider it as part of your 'official' notes, as discussed, that would in theory include your pre-supervision reflective diary. You may choose not to disclose this in the event of a Freedom of Information request, but if its existence becomes known (for example, through your supervisor), you may be compelled to submit it. What would a client see if they exercised this right, and would you be happy with them reading it?

**Context:** The adequacy of your records also depends on your working context. If you're in private practice seeing generally 'functioning' adult clients you may feel more confident writing brief notes than you would if you're working with complex trauma, children and young people, or clients with serious mental health challenges.

Records for work involving safeguarding concerns, risk management or vulnerable clients need more detail. If you're working in an agency or the NHS, organisational policies may specify minimum record-keeping standards that you're contractually obliged to meet. If you're working with clients who lack capacity to consent, or with children and young people, records take on additional significance because others (those with parental responsibility or legal authority) may have rights to access them.

**Accurate recall:** Your observation that you haven't 'forgotten anything important' raises several concerns. First, how would you know? Memory is reconstructive, not reproductive – we don't recognise what we've forgotten because the gaps fill in seamlessly. You may be confidently recalling sessions while actually misremembering key details.

## Points for supervision

Your evolved system seems to be working for you, but as you are seeking reassurance it's worth spending time in supervision to review the process and ensure that it 'works' beyond simply helping you recall client details and prepare for supervision. Notes need to work for multiple purposes: protecting clients, supporting clinical decision making, evidencing professional conduct, meeting legal obligations and ensuring accountability.

Good notekeeping protects both clients and practitioners. It supports better clinical work by helping us notice patterns we might otherwise miss, evidences our professionalism and provides protection when things go wrong.

The underlying question you're asking is 'how can I take notes efficiently while meeting professional standards?' The answer involves finding a system that balances the need for adequate documentation with the realities of sustainable practice – but that balance can't tip so far towards efficiency that it compromises our fundamental obligations to clients and the profession. For many practitioners the process of writing more comprehensive notes as soon as possible after sessions helps them reflect on what has happened. If we see notetaking as just a task to be done as efficiently as possible, do we risk overlooking its therapeutic value?

**SALLY BROWN MBACP** is a therapist and coach in private practice, and a freelance journalist and editor.

*This column is reviewed by an ethics panel of experienced practitioners.*

## READER RESPONSES

### Our notes are always a partial view, shaped by our own lens

Most therapists start out writing detailed notes, then gradually simplify as confidence grows. There is always a judgment call about detail. Longer notes can create a sense of false accuracy and can overstate certainty about what was said or understood. Our notes are always a partial view, shaped by our own lens. What matters is that they stay factual and observable.

I keep my own notes short but structured. A few consistent prompts help me record themes, interventions, agreed actions and any safeguarding concerns. It takes minutes and it means I am not relying on memory when things are complex.

So yes, brief notes can be enough when they are clear, factual and consistent. There is no single right or wrong answer on length but whether your notes genuinely support your ability to hold the work safely for the client you have today and the client they may be next week.

**LOUISE HEYWOOD MBACP** is a sex and relationship therapist and author of *The Therapist's Notes Book* (available from Amazon), created to support therapists with clear, ethical, real-world record keeping.

### The process of writing by hand has helped me make sense of the work

Reflecting on my own notemaking has led me to see the important part it's played in my working process. During my psychodynamic training I was taught to take 'verbatim' notes, which meant trying to capture everything that happened during a session. Over the years I came across therapists who, in the main, took shorter notes. I questioned the amount I wrote but continued to jot down all that felt pertinent in those 10-minute slots between sessions.

Sometimes my unconscious will unearth revelations during the week, and I'll jot these down too. But it is so often when reading my words back that I will see previously unnoticed elements; phrases that stand out powerfully or link to aspects of the client's wider story that had not been clear to me during or after the session.

I do believe I'd miss some of those deeper, more hidden elements without this reflective

process. If work is with unconscious processes at a deep level, words and feelings can be slippery, evasive and ambiguous. I like to capture words on the page before they're gone and don't always trust myself to remember important elements. But this process won't suit everyone. Some of my supervisees struggled to write up notes at all – we are all different.

**JO BISSEKER BARR MBACP (ACCRED)** is a private practitioner currently on sabbatical and writes a regular newsletter at **jobissekerbarr.substack.com**

### Notes are a resource, particularly when written with clients

When notes are relegated to an admin task, or feared as being potentially used in court, we miss so much, including their therapeutic value. Session notes are a resource, particularly when written with clients and used as part of the therapy. Not only does this add significant value to the work and the relationship, I also believe it addresses the power imbalance that often exists in therapy.

I have been working with clients in this way for many years. The notes often provide us with critically important insights that shape where the work goes, allowing me to adjust my approach according to client preferences.

When people come to therapy they verbalise or attempt to put into words their experiences. This provides a window into the client's world and how they make sense of things. Writing session notes is a way of capturing their words, noting the story they are telling themselves, the effects of that story, and creating space for the client's agency and skills. Sharing and discussing those notes provides an opportunity for the client to notice themselves in a different way and create new liberating stories. It does take practice and skill to write notes in this way but it is worth the effort.

Writing minimal notes is a missed opportunity for the therapist and the client, and I am sad about that. As the Persian poet Hafez wrote, 'The words we speak become the house we lie in.' If we say notes are just for us, that becomes the house we live in – a house of missed opportunity.

**KEITH OULTON MBACP (ACCRED), MUKCP** is a family and systemic psychotherapist and supervisor. His article about sharing client notes, 'Helping Ariel notice "other stories"', was published in *Therapy Today*, September 2023. **bit.ly/49TTC8g**

## HOW WOULD YOU RESPOND?

**If you have experience or a view on the issues raised in any of the following dilemmas we would love to hear from you. The 'Reader responses' section is for peer-to-peer sharing – you don't have to discuss all the ethical implications as these are covered in the main response. The maximum word count is 350 but responses can also be shorter. Please email your response or any questions to therapytoday@thinkpublishing.co.uk. All emails will be answered and we will let you know if your response will be published.**

### What counts as a clinical will?

I've recently set up in private practice and am aware I need to put in place some sort of clinical will. I have given my supervisor my passcodes for my notekeeping system on my computer and told my partner to allow my supervisor access if I became seriously ill or had an accident. Is this enough? **Issue:** April 2026 **Deadline:** 9 February

### Can I call myself a coach?

I have seen a decrease in new therapy client enquiries over the past year and am considering introducing coaching into my practice to boost my income. I worked in human resources before becoming a counsellor, which involved regular coaching-type work, and recently did a half-day CPD workshop on coaching skills. I have years of experience as a counsellor so I feel confident I could offer a safe and ethical coaching service, but what might I be missing? **Issue:** May 2026 **Deadline:** 2 March

**The dilemmas reported here are typical of those worked with by BACP's Ethics consultants. BACP members are entitled to access this consultation service free of charge. Appointments can be booked via the Ethics hub on the BACP website.**

### The act of writing cements the memory of the client

I believe the act of writing opens up thought and demands clarity. It requires internal reflection and a process of working through, which in itself may help clarify things in your mind. What's going on, what shifted during the session, what was their stuff, what was yours, what was co-created in the intersubjective space?

When I say writing, I mean the old-fashioned way. Research demonstrates that handwriting engages a broad network of brain regions, including sensory processing and memory, which aids retention and comprehension. Handwriting is inevitably slower than typing, which encourages you to summarise and consolidate the information in your own words. This necessarily refined encapsulation should lead to a deeper understanding and encoding of the material.

Writing detailed notes helps to get a broader sense of the session beyond the apparent, and to see the transference, the projection, the projective identification. Also, practically there is no way I could maximise the value of my supervision without detailed notes to remind me of the key moments and questions. The dilemma writer says 'so far, I haven't forgotten anything important'. How do they know? I think that's a question that also plays a large part in me maintaining my current notetaking process.

**NICK CAMPION MBACP** is an integrative psychotherapist, based in Derby, and a trainer. He writes at **substack.com/@nickcampiontherapy**

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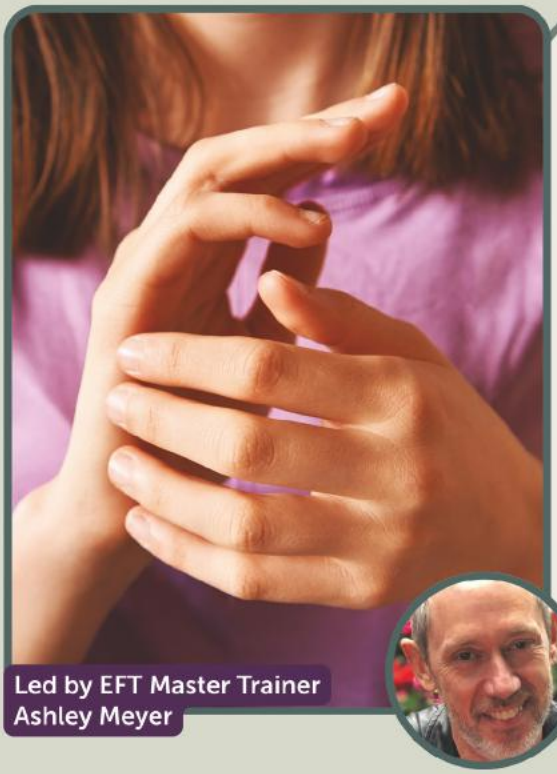

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# Not just a specialty

**Kel O'Neill** explores how eating disorders are going unsupported in therapy

KERONN ART/SHUTTERSTOCK

**Subject: Counselling after a break-up**
'Hi. I'm looking for some counselling. After a relationship break-up I started dieting to feel more confident and at first it sort of helped, but now I'm constantly worried about regaining the weight and still feeling rubbish about myself. I had a call with my GP, who said it didn't sound too serious, but I would still like to talk to someone. I'm wondering if this is something you could help me with?'

Enquiries just like this land in therapists' inboxes every day. Some therapists might read this and recognise the possible eating disorder (ED) straight away. Others may focus on the self-esteem challenges or the need for post-break-up support. Some may feel unsure: 'Is this an ED? Is this something I'm trained to hold?' Worryingly, some might even support weight loss as a goal[1] – not with any intention to cause harm but because we too have been shaped by a culture that presents weight loss as inherently positive, even therapeutic. We have therapeutic weight-loss services nationwide, such as nutritional therapy, supported by NHS treatments, including specialist weight-management services and prescription medications such as semaglutide (Wegovy) and tirzepatide (Mounjaro) for individuals with obesity and weight-related health conditions. If we haven't been invited to reflect critically on diet culture, these assumptions can sit quietly in the background, influencing our responses to our clients without us realising it.

## Spotting signs

The reality is that therapists are often left to navigate this complexity and these decisions – about scope of practice, competency, risk and referral – alone, and within a wider societal context that rarely equips us to recognise or respond to EDs with the nuances they require.

Most of us have had little to no training in this area and many have simply been told that EDs are a specialist issue that should be referred on. In my work as a therapist, supervisor and trainer specialising in EDs, I regularly encounter practitioners who feel ill-equipped to support clients whose central themes are food, body image or control. Comments such as 'we never covered this in training' or 'I don't know how far I can go before it's outside my remit' are frequent. These reflections echo the wider issue: therapists are being asked to manage presentations for which their training has rarely prepared them. There's a notable lack of conversation or clear guidance for counsellors and therapists about if, when or how to respond to ED-type difficulties in non-specialist settings. In one UK study just 3.4% of therapists reported having received extensive eating disorder-specific training, highlighting the scale of this gap.[2]

And it's not only the more ambiguous or subclinical cases that therapists are left holding. Some clients arrive with a diagnosis, a long history or severe symptoms but they're unable to access specialist services due to strict referral criteria or long waiting lists. Others have been discharged after brief treatment that didn't meet their needs. Increasingly clients tell us they've accessed specialist support in the past and found it unhelpful or even harmful. The consequences of this can be devastating. EDs carry some of the highest mortality rates of any mental health condition, with the most recent data suggesting death as an outcome is three times higher than in the general population.[3] Beyond mortality, many more people with EDs live with chronic health

complications, fractured relationships and the erosion of self-worth that comes from being repeatedly told they are 'not sick enough' to deserve care.

Whatever the specifics, these clients are presenting for therapy. And there's an urgent and growing need for better training, clearer guidance and a more realistic understanding of the role non-specialist therapists can and do play in supporting people with EDs. In my own work, both inside and outside the therapy room, I hear time and again that what many of those living with an ED need is the psychological and relational support so often missing from traditional treatment. They're looking for therapy that can hold their fear, shame and identity struggles, not just focus on their food intake or weight.

When this happens and therapy becomes a space for meaning-making, safety and connection rather than treatment focused on symptom control, clients often begin to re-engage with life and their own agency. This to me is good practice in action: therapy that sees the person, not just the presentation.

## Not niche

In fact, according to the Health Survey for England 2019, nearly one in five women and one in eight men aged 16 and over screen positive for a potential ED,[4] which is equivalent to around 10 million people across the UK. And since the pandemic it has been widely reported that ED referrals have increased and that presentations are often more severe.[5] To put this issue into context, in 2022 around one in six adults reported moderate to severe depressive symptoms.[6] In other words, EDs may be just as common as depression.

Despite these millions of individuals screening positive, only around 24,000 referrals to specialist adult ED services are made across England and Scotland each year[7] – that's less than one in 400 of those with possible symptoms being referred. While there are no equivalent figures for Wales or Northern Ireland it seems reasonable to say that the vast majority of those with ED-type struggles in the UK are not being supported by relevant specialists, if at all.

Also, it's important to recognise that even with this small proportion reaching the services they need, those services are already overwhelmed. In many areas, adult ED service waiting times are many months, and I've known individuals who've had to wait beyond two years in some areas. Referral criteria are also often narrow and exclusionary, focusing heavily on physical indicators such as body mass index (BMI) – a height-to-weight ratio often used to assess health risk, despite its many limitations – regardless of the widespread recognition of how poorly these metrics reflect actual need. The landscape isn't much better in children and adolescents' ED services either, with young people reportedly being told to utilise self-help, family support and charity services.[8]

The result is that 399 in every 400 adults and many more young people who screen positive for a possible ED are not under specialist care. Most are likely left to cope alone, while others turn to general therapy spaces or the charity sector in search of support.

These people may turn to therapists who have inadequate training, awareness or ED-specific knowledge, and who may, despite their best intentions, inadvertently reinforce disordered behaviours or harmful cultural narratives, such as encouraging weight loss, normalising restrictive eating or dismissing body concerns. In my training workshops I often see therapists realise that they may have unintentionally contributed to this kind of harm. For some that moment comes when they recall ending therapy once an ED became apparent – knowing the client would face a year-long wait for specialist care but feeling too uncertain to hold the risk themselves. For others it's the dawning awareness that they once supported a client's weight-loss goal, only later recognising that an ED may have been driving those behaviours. These are not failures of care but reflections of a system that leaves therapists underprepared and unsupported.

This situation is one I also see regularly in the details shared during case-specific supervision, and it places therapists in a deeply uncomfortable ethical bind: on the one hand we're told that EDs should only be treated in specialist settings; on the other we feel we have a moral

*'I hear time and again that what many of those living with an eating disorder need is the psychological and relational support so often missing from traditional treatment'*

## Refer on or offer support?

**Neither option is inherently right or wrong. There are times when stepping away is the most ethical and appropriate course of action. However, even then, how we do it matters. A well-handled referral can be collaborative, compassionate and reassuring – a warm conversation that includes signposting, transparency and emotional containment. In contrast, a flat 'this isn't my area' followed by a quick discharge can leave clients feeling ashamed, unsafe or as though their distress is too much to be held, echoing the very themes that so often sit at the heart of ED experiences.**

If you decide to stay with the work, whether that's to support someone while they wait or in the absence of specialist care, it's worth recognising that there's no single right way to proceed. While there's very little guidance on how general therapists might navigate this, in my professional experience there are things you can do to approach the work safely, thoughtfully and ethically. Examples include:

**Gently name what you see.** Therapists often hold back from asking about or naming possible eating difficulties, but reflecting back what you notice can open the door without labelling or pathologising.

**Ask about food and body like you ask about mood, sleep or thoughts of harm.** This isn't about 'screening' for an ED but recognising that food struggles can be linked to many other difficulties. Spotting a shift early on (like a low appetite in depression) might help you support the client to nourish themselves and avoid further decline.

**Don't wait for 'severe enough'.** Many EDs, especially binge eating disorder (BED), bulimia nervosa or restrictive patterns in higher-weight clients, don't meet the outdated image of what EDs 'look like'. But distress is the key. If food, weight, shape or size are becoming central ways of managing emotion, self-worth or identity, they deserve attention.

**Encourage GP involvement and make it about health, not weight.** Where ED-type patterns are present or suspected it's wise to suggest regular medical monitoring such as appropriate blood tests and blood pressure and heart rate monitoring, even if the client isn't underweight or obviously physically struggling. Encourage this support proactively and explain that it's about their physical health and safety, not judging or policing bodies.

**Be alert to risk but also to shame.** While it's vital to assess for risk (such as medical need, suicidality and self-harm) it's just as important not to fuel shame. Clients with eating difficulties are often hyper-aware of being judged, dismissed or misunderstood. Stay collaborative. Be part of their support team, not a source of further fear or disconnection.

**Be transparent about your scope – but don't vanish.** It's OK to say: 'I don't specialise in EDs and I might encourage you to seek out specialist support, but we can also explore what's coming up and see how I can support you.' Clients often fear being shut down. Sometimes, staying present with curiosity and care matters more than having all the answers.

**Don't stop referring but don't step back while they wait.** Referring to ED services is still very important when appropriate and available, but we also need to recognise that referral might mean waiting months, or result in discharge without treatment. With some basic understanding you can help clients feel less abandoned during this gap, provide support when no specialist help is available or aid them to find someone who is able to support them.

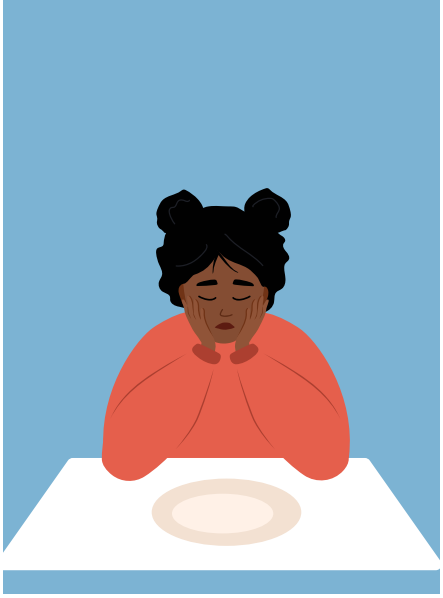
**Learn how EDs affect thoughts and behaviour.** Rigid rules, looping fear and identity enmeshment are common in those with EDs. When you understand the traps EDs create – the stuckness, ambivalence and protective logic – you're better equipped to stay relational rather than reactive. Knowledge is very much power in this instance.

**Focus on meaning, not just behaviour.** EDs rarely exist in a vacuum. Instead of focusing solely on food or weight (which may collude with the disorder), explore what those behaviours protect against, what they communicate and what purpose they serve. This can often be done safely without stepping outside your competence.

**Be aware of your own biases.** We've all been shaped by diet culture. Ask yourself: would I see this behaviour as concerning in a smaller body? What assumptions are you carrying?

**Taking time to explore what we bring into the room can help us approach this work more consciously and ethically. The following questions offer a useful starting point:**

- How do I feel about referring clients for medical monitoring? Am I clear on what's appropriate and do I feel confident in having those conversations?
- What language do I use when talking about food, weight or health? Might any of it reflect unexamined assumptions or cultural norms?
- What comes up for me when clients talk about eating or body image?
- What do I believe makes someone 'sick enough' to need support? Where do those beliefs come from?
- What support is in place for me? This includes supervision, CPD and peer spaces.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*'In the absence of clear pathways we're often left navigating this work with more questions than answers, but uncertainty needn't be a barrier to good practice'*

responsibility to support someone sitting in front of us with nowhere else to go.

It's a dilemma that leaves many therapists questioning what's right. Do we step in and try to help, despite feeling – or likely even being – under-equipped? Or do we step back knowing that doing so might mean leaving someone without any support?

## Guidance needed

The lack of clear and realistic guidance only amplifies this challenge. There's a gap here that underscores the need for systemic change – an evolution in how the counselling and psychotherapy community is educated and supported to respond to clients with EDs.

It's vital that comprehensive training programmes that address the multifaceted nature of EDs become a standard part of the curriculum for counsellors and therapists. Beyond formal education we need an open dialogue where questions about competency, referral practices and risk management are met with collaborative solutions rather than untenable advice.

We also need more research, not just into clinical treatments but into what works (and doesn't) in everyday therapy rooms. As part of the Lived Experiences of Eating Disorders (LEED) Research Collective we're currently exploring how professionals understand and navigate BMI-based referral and treatment criteria; a study highlighting the tensions and dilemmas faced when supporting clients within restrictive systems. Beyond this there's also a need to understand how general therapists are navigating this work, where the gaps are and what ethical, effective support really looks like when specialist services aren't accessible. Only then can we begin to address this widespread issue effectively, ensuring no client is left unsupported in their journey towards recovery.

However, while we wait for systems to evolve, clients are still walking through the door. They're sitting opposite us *now*. So the question becomes: what can we do, here and now?

This begins with a decision that each of us as individual practitioners must make when ED-type struggles show up in our room: do I refer on and step back or do I offer support within the limits of my competence [see left]?

Supporting clients with EDs isn't always straightforward, but with reflection, curiosity and more knowledge, it's work that many therapists could be well placed to do.

In the absence of clear pathways we're often left navigating this work with more questions than answers, but uncertainty needn't be a barrier to good practice. It can be an entry point if we meet it with openness, honesty and a shared commitment to doing the best we can with what we have.

EDs don't need to become a specialism for every therapist but they are part of the landscape of distress we are likely to encounter. Given their prevalence, complexity and the current gaps in service provision, there's a growing need for all of us to be able to recognise them and to build the confidence and skills to support those who might otherwise fall through the gaps. This is my call to the therapy profession and to all therapists, not only to reflect and respond in our own work but to speak up: about our capacity to support people with EDs and the urgent need for better guidance, more inclusive training and research that enables us to do so safely, ethically and well. ●

*Kel O'Neill's 30-minute session on 'The changing landscape of eating disorders and therapy' takes place at Making Connections Wales on 25 February.*


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## ABOUT THE AUTHOR

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# The invisible thread

Overcoming low self-esteem from childhood bullying inspired her own specialism as a therapist, says **Natasha Page**

When I started therapy in my early 20s I thought I was there to deal with stress and low mood. What I didn't expect was to discover that all my struggles were connected by one hidden thread – low self-esteem. Back then I didn't really understand what low self-esteem was. I also didn't know what therapy could offer me.

Like many of the clients I now support, I went through a period of depression where even getting out of bed felt overwhelming. Motivation was hard to find, and beneath it all was a deep sadness that I didn't share with anyone; I kept it locked inside. I became highly self-critical and never felt that I was good enough. Working as a busy receptionist at the time, I often felt people took advantage of me, piling on tasks with little regard or respect for me as a person. Looking back I can see that these thoughts and feelings were not a reflection of my worth but symptoms of low self-esteem that then fed my depression.

The day I found myself in tears at the thought of having to get up and go to work was the most significant indication that something needed to change. So, in my desperate effort to feel better, I decided to attend my first therapy sessions. I'm so grateful I did because therapy revealed to me that how I valued myself deep down was influencing every aspect of my life. That realisation not only changed me personally, but it also shaped the therapist I became. Today I believe one of the most powerful things we can do in therapy is to help people recognise and understand self-esteem. Because without that awareness they may never see how much it influences their experiences.

## Feeling less than

My story began much earlier. From the age of 10 I faced bullying for being overweight and for my hair, which was different in texture and style compared to other children's. Neither Black nor white, I struggled with my sense of identity. Too often I felt like I didn't belong anywhere.

At an age when fitting in feels like everything, being targeted for how I looked and who I was left deep scars. Those years of bullying carried into my teens, and I began to absorb the message that I wasn't good enough.

Erikson described adolescence as the stage where we're trying to answer, 'Who am I?'[1] When bullying attacks the very core of our identity it can create long-lasting confusion and pain.

Social identity theory also provides insight here.[2] Part of our self-worth stems from belonging to groups. When you're told your group is 'different' or 'less than' it erodes your sense of self. Research confirms that children who face bullying are more likely to struggle with self-esteem and mental health later in life.[3]

## Core beliefs

By my teenage years the belief that I was 'less than' had already taken root. I turned to unhealthy coping strategies such as drinking, drug use and even shoplifting. Shoplifting was far removed from who I truly was – a meek, kind and loving person. Yet in those moments, stealing make-up and clothes gave me a fleeting sense of escape – a way to feel good about myself when deep down I didn't.

When you don't believe in your own worth it changes what you accept in life. In my late teens and early 20s I made choices from a place of needing validation. I married young, not because I was truly ready or deeply in love but because I craved security and acceptance. Research shows that people with low self-esteem often expect rejection and so settle for less in relationships, believing they don't deserve more.[4] Looking back I can see exactly how that played out for me. At the time though I couldn't have explained any of this. I just knew I felt anxious, disconnected and unfulfilled. Like so many clients I see today, I was experiencing the symptoms of low self-esteem without knowing its name.

Therapy gave me what I didn't have before – awareness. I went into therapy wanting to talk about my low mood and work stress, but slowly, with the help of my therapist, I uncovered the belief sitting at the heart of everything: 'I am not good enough.' The bullying created a core belief of unworthiness that shaped how I thought, felt and behaved. Recognising it was the first step in changing it.

## Psychoeducation

One of the most life-changing parts of my therapy wasn't just the talking but the learning. I will never forget the moment when the penny dropped for me. It was when my therapist summarised back to me my words and then added his opinion that he felt I was experiencing low self-esteem. When I reflected on it, it all made sense. And I could see that what he was suggesting was indeed low self-esteem. My therapist explained what self-esteem is, how it develops and how it influences behaviour. Suddenly, things that had felt confusing for years started to make sense. This is the power of psychoeducation. It isn't about lecturing; it's about providing people with the knowledge that helps them understand themselves. Studies show that psychoeducation can reduce symptoms of depression and anxiety and assist individuals in managing their difficulties more effectively.[5,6]

In my own work now as a therapist I often see the same thing. A client may come in describing people-pleasing, perfectionism or fear of failure. When I gently say, 'This sounds like low

***'I believe one of the most powerful things we can do in therapy is to help people recognise and understand self-esteem'***

NEIL WEBB/IKON IMAGES

*'Clients may talk about relationships, work stress or anxiety but, underneath, a lack of self-worth might be silently shaping it all'*

self-esteem' it can be a revelation. Naming it gives them a way forward. Sometimes even simply pointing out the language clients use about themselves – harsh, critical, unforgiving – can open their eyes to the role self-esteem plays. Awareness is often the first step towards healing.

What started as a personal journey soon became the foundation for my professional development. After the life-changing therapy I had received, it served as my catalyst to pursue a career change and follow what I felt was a calling to help and support others in the way I had been helped.

## Common denominator

As I trained and began working with clients I was struck by how often low self-esteem presented itself. It might not have been the reason someone booked a session but time and again it emerged as the thread running through their struggles. Whether it was imposter syndrome, relationship difficulties or burnout, the common denominator was self-worth.

Too often self-esteem is treated as a secondary issue or discussed vaguely, but in my experience it can be the invisible thread. Clients may talk about relationships, work stress or anxiety but, underneath, a lack of self-worth might be silently shaping it all, and helping clients to see and name that can be one of the most transformative parts of the therapeutic process. Sometimes we can do this through a well-timed observation such as, 'I notice you're being very hard on yourself.' Or, 'What you're describing sounds like it might be connected to self-esteem.' Those moments can be pivotal.

It is crucial to hold in mind that recognising low self-esteem is one thing but rewriting that story is another. For many clients, especially those who have experienced abuse or who have been marginalised for their sexuality, gender or neurodivergence, this work isn't a quick fix. It's a slow process that often involves more setbacks than progress. As therapists our job is to resist the urge to 'fix' and see tangible progress, and instead honour their pace, no matter how slow it may seem. It takes skill and courage to sit with clients as they unlearn at their own pace the harsh narratives they have carried for years.

## Changing lives

Looking back now I can see the clear thread – growing up mixed heritage, the bullying I endured, the choices I made in early adulthood and the weight of depression I lived with. At the heart of it all was low self-esteem. That realisation shaped not only my own healing but also the way I now work with others.

Twenty years on from the day I first walked into that therapy room I've achieved more than I ever could have imagined. I've trained and qualified first as a social worker, then as a counsellor and psychotherapist. I've built a thriving private practice, spoken confidently to large audiences and, most recently, signed a publishing deal with a respected publishing house to bring my first book into the world, an achievement I never could have imagined in my 20s.

But I've learned that overcoming low self-esteem is a continuous journey. There are still moments when that old critical voice sneaks in and tells me I'm not good enough. The difference now is that I know how to meet that voice with compassion rather than fear. In many ways I value those moments; they keep me grounded, humble and deeply connected to the clients I work with. I know exactly what it feels like to be in that place of self-doubt, and I also know the incredible freedom that comes from embracing self-love and viewing yourself through a more compassionate lens.

Therapists truly have the power to change lives, and my very first therapist altered the course of mine – helping me heal and grow and create a life I never thought possible. I carry that gratitude with me every single day. It's why I feel so deeply honoured to now work with others on their own journeys, in the therapy room and – through my book – beyond, reaching people I may never meet but who need to be reminded that they too are worthy of so much more. ●


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# More than a feeling

**Barry Gibb** explores the neurological basis of empathy and its significance for client-led therapy

On the first day of my master's in counselling and psychotherapy I was told how important empathy is. But as a scientist, filmmaker and practitioner aiming for congruence, I found myself wondering what exactly *is* empathy: what is happening in the brain when one human being empathises with another? This led me to explore empathy from a personal, therapeutic and scientific perspective, while endeavouring to find a way for all of us to get better at what we do while avoiding potential pitfalls that can lead to burnout.

## Faces of empathy

As a filmmaker, sitting opposite me in sunny Hastings is Barbara. We discuss her cancer and knowledge of imminent death. On another day I meet Pete in rainy Scotland: he shares details of his near death experience following a heart attack. The interviews are intimate and personal, eliciting that holy grail of the interview process: a transcendent, confessional state in which a person opens like a flower, sharing their deepest truths with you. Today, as a therapist, I reach for a similar state in which therapeutic levels of empathic contact can be attained.

While there are similarities between therapeutic empathy and the empathy I experienced with my interviewees in a filmmaking setting, they are, I've come to discover, distinct. Rogerian empathy is about accessing the client's frame of reference. One purpose of successfully accessing the client's frame of reference, in an atmosphere of complete acceptance, is the hope that they could start to experience themselves safely, 'more truly and deeply, to choose more significantly'.[1] In essence, by experiencing my acceptance and trust, the client is more able to trust their own internal locus of evaluation and move closer to self-actualising.[2]

My experience of empathy is that it is a form of metacommunication – an innate quality that evolved to enable us to survive and thrive in social contexts.[3] When with others we unconsciously absorb every nuance of information about them – body language, pheromones, speech inflections and pauses, breathing patterns – then effortlessly distil our perceptions into a felt sense of their mental state. For counsellors this connection is far deeper than just

YULIYA CHSHERBAKOVA/SHUTTERSTOCK

'getting' someone; it allows us to venture more deeply, to sense feelings and thoughts the other person may not be aware of themselves. The client shimmers with feelings and our mental connection becomes tangible, words less vital as we collaborate in a common language of their feelings, allowing therapeutic insights and understandings.

## Brain regions

Empathy spans both social and medical dimensions. While we see and feel its impact in the world, it is also neurological and resides somewhere within the brain, in the same way vision or memory does. Exploring the social neuroscience of empathy, I discovered that as counsellors we are most interested in what is called 'affective' or 'emotional empathy'.[4] This is functionally distinct from 'cognitive empathy', which is more akin to the theory of mind, which describes an animal's (chimpanzee) ability to understand the mental state of another (joy, anger, confusion) without necessarily feeling it. This ability to sense the inner world of another allows us to predict behaviour, facilitating social interactions.[5]

As with many aspects of human biology, there is person-to-person variation, which may have implications for working with neurodivergence or psychiatric diagnosis,[6] but further research is needed, allowing for greater therapeutic connection rather than medicalisation or othering clients.

Functional imaging studies reveal affective empathy consistently becomes activated in two brain regions associated with the salience network – a frontal, cortical region of the brain that has been observed to activate in response to experienced or observed pain.[7,8] This network comprises the anterior insula – associated with awareness of bodily sensations and the subjective experience of emotions (particularly in others) – and the anterior/mid cingulate cortex – where sensory, motor, cognitive and emotional information is integrated.[8-11]

## Therapeutic relevance

A core part of my therapy training and integral to BACP's *Ethical Framework* are ideas around unconditional positive regard (UPR) alongside respect, equity and cultural humility. At the same time I am a white, heteronormative, neurotypical male. This poses a potential conflict: research on affective empathy has demonstrated a multitude of factors determining a person's empathic response to another person. These factors include trustworthiness, social status or perceived closeness,[12] while other studies have demonstrated a greater degree of empathic response to your own ethnic group.[13] These disheartening findings heighten the professional value of doing as much as I can to learn about cultural difference – including different beliefs, histories and lifestyles – to develop a more equitable empathic response to another human. This knowledge instils an even stronger motivation to learn about humanity while also understanding why it matters so much in the context of empathy within the therapeutic space.

***'When with others we unconsciously absorb every nuance of information about them then effortlessly distil our perceptions into a felt sense of their mental state'***

## Too empathetic?

Rogers wrote: 'When I am at my best as a therapist, I discover another characteristic. I find myself, in a strange way, to be both fully in and fully out of the experience.'[14]

This connects with my understanding of therapeutic presence and congruence, that while I'm seeking a deep-felt sense of another's feelings, I'm also able to maintain an awareness that they are not *my* feelings, and acknowledging my own reaction to those feelings. The reason it's so important to keep one foot out also appears to have a scientific foundation: findings suggest we are prepared to help another person we see in distress – but only up to a point. Once our own distress, in response to another's, exceeds a certain point, prosocial behaviour – a type of behaviour associated with affective empathy in which we act to help others – breaks down and we seek to take care of our self.[15]

These findings help me grasp the importance of developing my capacity for professional empathy. If I allow myself to commit too fully to an empathic state while in the presence of someone sharing a powerful trauma, I may become too upset to empathise, emotionally retreating from them. So how can we do our best to be ready for what we experience in the room?

## Compassionate mind

In counselling therapists endeavour to reach a state of empathic concern, ie compassion. What distinguishes affective empathy from compassion is *intention* – a prosocial desire and motivation to help another.[8,16]

A recent meta-analysis of 16 functional MRI studies[8] explored several brain regions that were active during a range of experiments designed to measure compassion. As in affective empathy, the salience network was consistently activated during such experiments. In several experiments the authors also found activation of the periaqueductal gray network, located in the midbrain. This circuit, deep within the brain, has been associated with pain modulation, anxiety, reproductive behaviour and hormones, such as oxytocin. The authors suggest that this fundamental 'care circuit' may become contextually activated during certain types of compassionate behaviour.

In other words, compassion – towards yourself and others – is far more than simply caring; it is the most salient dimension of empathy to nurture within the healthcare professions. It improves care, develops resilience and prevents burnout in both trainee and qualified therapists.[17-19]

Furthermore, compassion can be improved with training.[20-22] This is already being used within healthcare professions to improve quality of medical care[23] and training.[24] Compassion training is largely based on ideas of mindfulness, recognising your own emotions and those of others, while highlighting the value and purpose of empathic communication. And it doesn't take much to have a positive impact: one single day of 'self-compassion for healthcare communities' training in paediatric nurses was found to improve their resilience while also improving their overall wellbeing.[19]

## Compassion fatigue

Compassion fatigue is described by Klimecki and Singer as 'the willingness of an individual to place the needs of others above him or herself to the point of causing harm.'[25] This reinforces the idea that there are limits to how much empathic concern someone can regularly feel before their mind maxes out.[15] In my own life I have happily placed a great deal of emphasis on putting the needs of others above my own without fully acknowledging the implications of not developing a robust enough compassion base upon which to practise. I've meditated daily for a decade, have a supportive family network, and love nature, movies and creative pursuits. And now, thanks to my training, I keep a reflexive journal in which I interrogate my inner world, and have undergone therapy that continues to bring a greater sense of being at peace. But are these enough? Most of these self-care strategies have evolved retrospectively over years to cope with workload, stress, confidence, grief and burnout, but how might I manage across future years of being exposed to the trauma, suicide ideation or abuse of others?

## Trainees

Therapists who work in a client-centred way need to do more to proactively help build compassion and therefore mental resilience in trainees so that we can avoid potential psychological harms that can be experienced when repeatedly exposed to emotionally challenging situations.

In 2016 the idea of compassion training for trainees was proposed in the Beaumont paper 'Building resilience by cultivating compassion'.[21] In it, wider use of compassionate mind training (CMT) is proposed.[26] This is an approach created to help individuals dealing with high

YULIYA CHSHERBAKOVA/SHUTTERSTOCK

*'Understanding more about the underlying mechanism of empathy could have widespread benefits for anyone engaged in modalities in which empathy plays a critical role'*

levels of self-criticism and shame. The use of CMT along with person-centred and counsellor themed workshops and classes could provide a strong foundation, building compassion for self and others alongside greater resilience. Discussions would be encouraged regarding how experiences such as working with suicidal patients, or a lack of supervision or support in the workplace, can impact wellbeing. Students could examine role-play scenarios that engage with the angry self, sad self, anxious self and self-critical self, and scenarios relating to organisational, client, academic and placement demands could be explored.[21]

The core conditions of empathy, UPR and congruence quickly became mantra as I learnt to try and embody Rogers' teachings. To be fully congruent I need to acknowledge that working with clients may take an empathic toll over time, and therefore work hard from now to counteract or minimise this through regular engagement in compassion-based training exercises.

## Relational depth

Relational therapy stands out as placing primary emphasis on empathic connection and relational depth *between* counsellor and therapist to facilitate change. Research demonstrates that empathy deserves further investigation. Understanding more about the underlying mechanism of empathy could have widespread benefits for anyone engaged in modalities in which empathy plays a critical role. Ultimately, affective empathy, a uniquely human quality in which we can deeply sense the feelings and *implied* meanings of another person, is the cornerstone of Rogers' therapeutic process and, with the added dimension of an intent to help, is transformed into compassion. To avoid empathic pitfalls, research suggests it is incumbent on us to embrace cultural humility and learn as much as we can about the vast array of people whom we encounter – because not to do so limits our ability to empathise beyond our cultural awareness. We must endeavour to maintain an appropriate level of relational depth by working consciously to keep one foot out – allowing us to remain with the client as a confident companion, even as they explore tremendously difficult issues. Meanwhile, to prevent burnout, we can develop and train our compassion, using training exercises with a focus on compassion towards both self and others. ●


### ABOUT THE AUTHOR

**Dr Barry Gibb MBACP** is a person-centred counsellor who blends compassionate, client-focused therapy with a unique creative and narrative-driven approach, drawing on his PhD in neuroscience.
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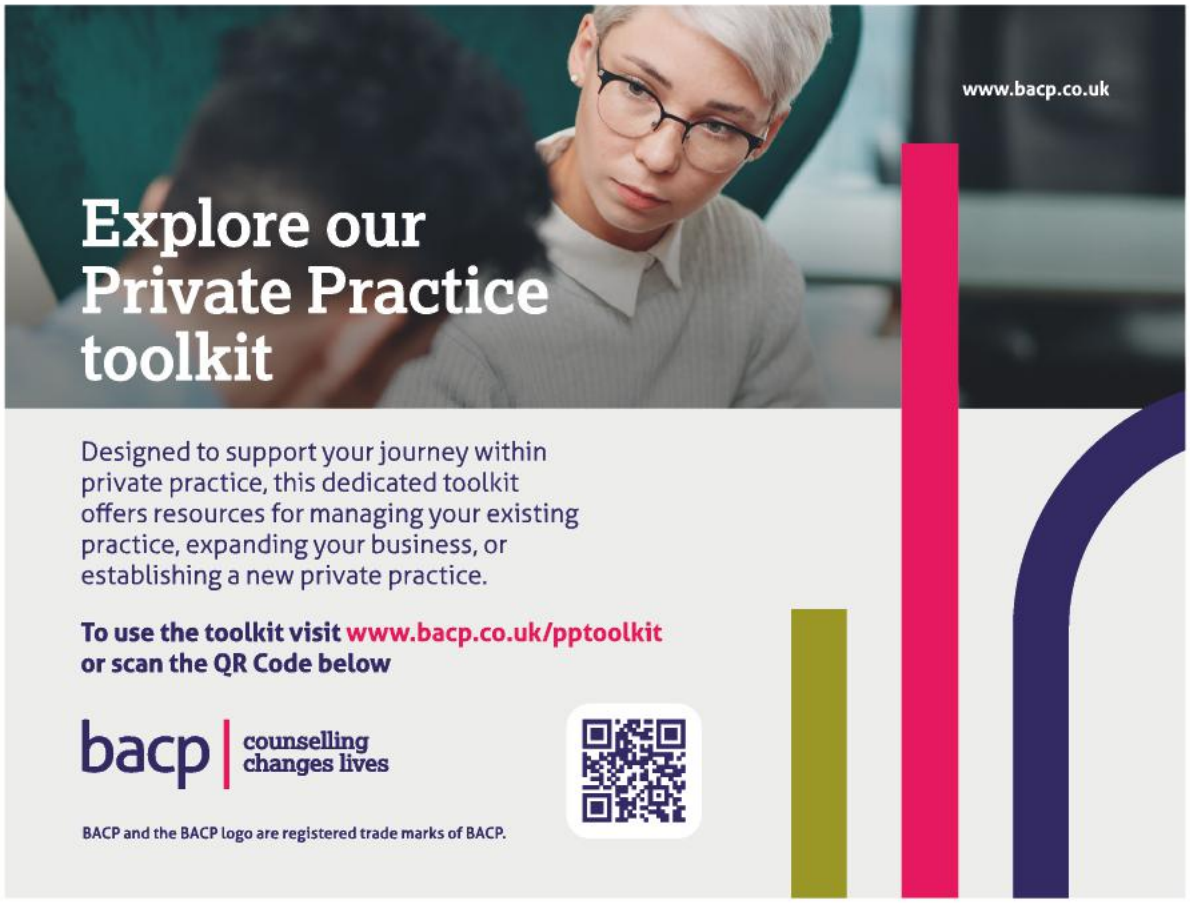


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# What in the name of Narcissus is this?

## **Julia Bueno** argues why the rise of 'therapy speak' matters

After negotiating space for my lunch on a train table with a young woman, I fell into conversation with her about the purpose of her books and laptop. She was a master's student and having a tough time with her university's administration, and her tutor in particular. In the half an hour or so of chatting she described him as a narcissist who gaslit her. She felt burnt out and angry that there was no safe space for her to go. I couldn't be sure what she meant by these terms of so-called 'therapy speak', even though I'm a psychotherapist. They, and many other words and phrases from consulting rooms and diagnostic manuals, have percolated into the mainstream, and have been diluted or added to on the way.

Our new dialect of therapy speak seems to be everywhere – Margot (as I came to know my train friend as) is part of a generation that describes experiences and relationships in these psychological and emotional terms. She reflects how we have, more generally, become far more aware, and interested in, our minds and emotions, and that we want to attend to, and maybe prioritise, our wellbeing. This must be a good thing in a world that continues to create pain and suffering at a seemingly exponential rate. Margot's way of thinking and talking advocates for a better understanding and acceptance for all our varied stories, and makes my profession far less of an aloof one than it was when I began to practise 20 years ago.

However, therapy speak has no agreed upon dictionary or glossary to refer to, and its developing terms can mislead or even confuse others. I set up a Substack to offer a guide to many (now mainstream) terms in the hope that we can come to more of an understanding of them when used in conversations of all types. My understanding of 'gaslighting' turns out to be very different from Margot's, and while her tutor certainly sounded deeply unpleasant to say the least, I was not sure that his behaviours would stack up to the meaning of a 'narcissist' that I know.

Therapy speak isn't entirely new of course. I came into adulthood in the early 1990s knowing very little about what mental health or ill health meant. I remember my mother's reference to my potential 'inferiority complex' (a term of Alfred Adler) as a much younger sibling, and references to punishing 'superegos' (a term of Sigmund Freud), but these were rarefied concepts of readily dismissed 'psychobabble'. My friends and I had no grasp of what terms like these *really* meant and only a privileged – or really unwell – few who went to therapy did.

Psychotherapy was an aloof practice for a very long while, associated with its Freudian psychoanalytic form or Woody Allen films ('patients' lying on a couch describing their dreams), or maybe as Californian hippies 'rebirthing' or 'primal screaming' at the Esalen Institute. Most of us muddled through bad days, bad sleep and bad break-ups without deep enquiries into our inner worlds or analysis of the relational dynamics between ourselves and others. Maybe, more accurately, we kept such analysis private.

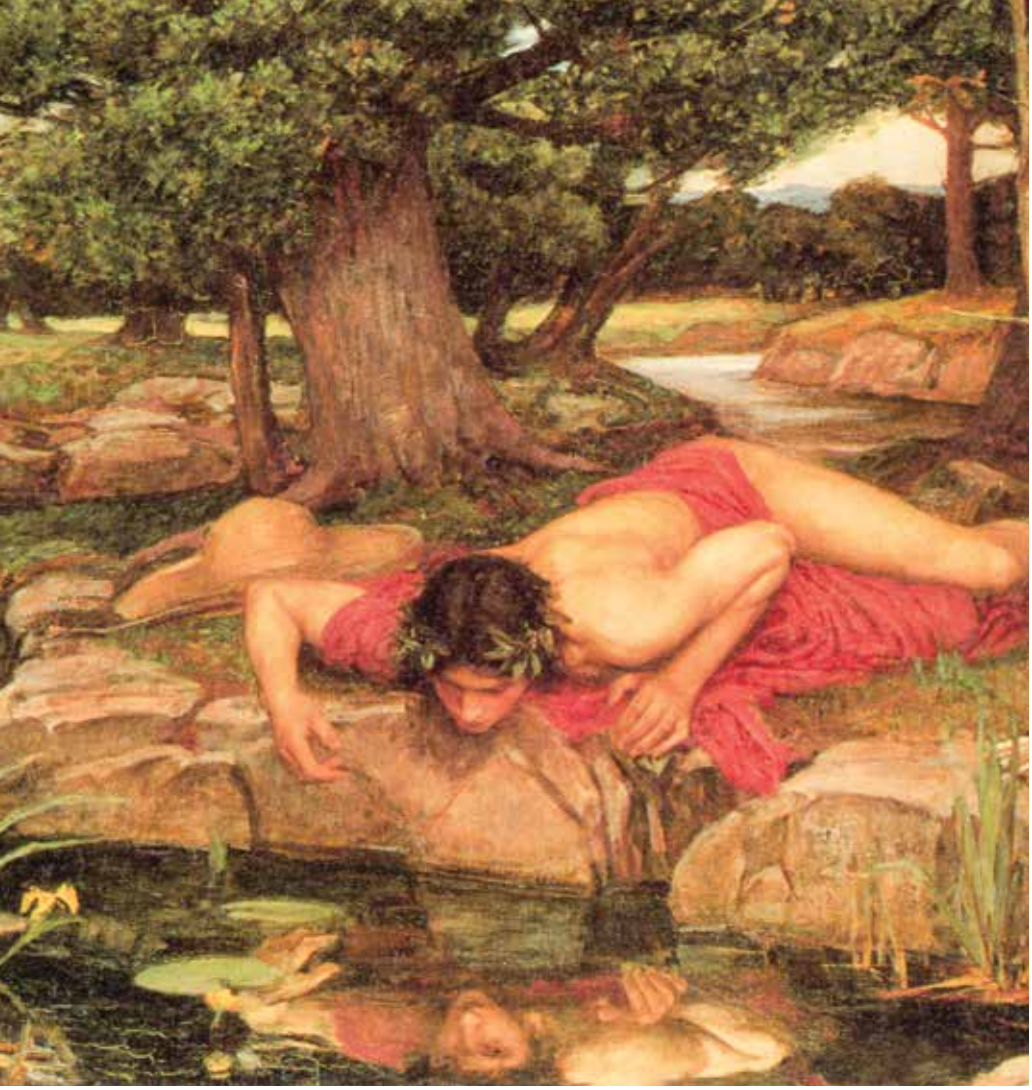
'Stressed' was about as nuanced as many descriptions got in my teens. It described the reason my friend's mother 'went somewhere to rest' (I later found out she was admitted to a psychiatric ward for depression), and it was also the reason for another friend's sister's admission to a hospital for her 'stomach problems' (a specialist 'eating disorders service' didn't then exist). We now use many more words – accurate or not – to share, far more readily, the contents of our minds, the range of our feelings, emotions, bodily experiences and presentations, and the details of how our experiences play out. Much of this is online of course: in social media posts and TikTok reels, YouTube videos and Substacks, with all the likes and follows.

The US critic Lauren Oyler's biting 2024 essay 'The power of vulnerability' describes many of these personal outpourings as a 'controlled release of intimate details'.[1] She notes a cultural emphasis on being 'authentic' and emotionally open – especially on social media platforms – that ultimately persuades us to present our vulnerabilities in a curated and performative way. She is concerned that when such self-disclosure becomes self-marketing, it strays from being a genuine communication, nor, she suggests, could this be truly transformative for the person who shares their inner world. I worry that therapy speak runs the risk of us doing something similar too – pulling us away from what we may really mean to say – which is why I want us to take care about the terms that we use.

When I told Margot I was a psychotherapist her face lit up with interest, and she shared her experiences of her own various talking therapies. The

***'Therapy speak has no agreed upon dictionary or glossary to refer to, and its developing terms can mislead or even confuse others'***

ECHO AND NARCISSUS/HISTORIC COLLECTION/ALAMY



growth of therapy speak has tallied with the normalisation of what I do. Twenty years ago, when I began clinical work, revealing my profession usually clammed people up. Some clients would come to see me in secret, paying in cash for fear of a partner clocking their weekly outgoing. Others described me as a 'work coach' to their families or on their bank transfers. This was around the time the 2004 bestselling book *Watching the English: the hidden rules of English behaviour* was first published.[2] Written by Kate Fox, a social anthropologist, it discerned 'the understatement rule', where: '...a debilitating and painful chronic illness must be described as "a bit of a nuisance"; a truly horrific experience is "well, not exactly what I would have chosen"... an act of abominable cruelty is "not very friendly", and an unforgivably stupid misjudgment is "not very clever"...'

While the understatement rule persists (to the amusement of my Dutch friends), the growth of therapy speak suggests another, opposite, cultural manner exists too, which is to 'say it as it is'. Because we may be using ill-defined terms though, this might mean *wrongly* or *over*stating things, which is why I want us to take stock. These days many of my clients talk about their therapy with others and they no longer hide me, and may even introduce me to their families or friends if we meet accidentally. Some tell their work colleagues why they come in late on a Wednesday, or ask their flatmates to be scarce when we meet on Zoom.

Interestingly Fox's book landed on the shelves around the same time as a controversial one that hit a very different note: *Therapy Culture: cultivating vulnerability in an uncertain age*.[3] Written by the Hungarian-Canadian sociologist Frank Furedi, he has a particularly loud voice among many critics of the 'problematisation of everyday life' that many see has escalated over the past two decades (also described by other thinkers as 'therapism').

Furedi points to a cultural overemphasis on emotional vulnerability, and laments the medicalised treatment (via therapeutic interventions) of 'normal' human experiences such as grief, depression and anxiety. He contends that our 'therapy culture' has eroded traditional sources of meaning and authority such as religion, family and community, and argues that, ultimately, our sense of individual autonomy and personal responsibility has ebbed. His voice hums in the background of books published this year that challenge overdiagnosis of mental health problems.

There are other ideas that reverberate through the therapy speak debate – two related ones are 'semantic bleaching' and 'concept creep'. The former refers to words losing meaning, which happens naturally as language evolves. When I was a teenager 'wicked' meant 'awesome', and 'queer' was derogatory. Reluctantly I accept that 'literally' now most often means 'figuratively', as it did for the woman I overheard exclaim 'I know! I literally died! Twice!'

I nod to the fact that therapy speak runs the risk of semantically bleaching the diagnostic meaning of certain illnesses. Overhearing 'I'm OCD about cleaning the kitchen' offends my client who cares for her daughter imprisoned in her bedroom for three years by her terror of contamination. Saying 'I felt really depressed yesterday' riles another who I often speak to on the phone from under her duvet because she can't face seeing me online, let alone making the 10-minute walk to my consulting room. Fearful of adding more bleach to such words, some of my clients, and supervisees, are now reluctant to use them even in appropriate ways, just in case they are overdoing it.

Meanwhile 'concept creep' concerns words that expand in meaning over a shorter period and tend to do so

## *'Today's increased interest in mental health and psychological functioning offers an opportunity for us all to think about the words we use more'*

because of a more conscious desire for change. This phenomenon was originally outlined by Nick Haslam, a professor of psychology at the University of Melbourne, in 2016 in an oft-quoted paper, 'Concept creep: psychology's expanding concepts of harm and pathology'.[4] He had noted a trend beginning in the 1980s in the social and psychology fields of the broadening definition, or 'semantic inflation', of six concepts: 'mental disorder', 'abuse', 'addiction', 'bullying', 'prejudice' and 'trauma'.

Haslam thinks that these concepts are expanding both 'horizontally' and 'vertically'. 'Horizontal creep' happens when a term absorbs qualitatively new phenomena, in the mode of metaphor. So, using the example of 'bullying', when I was in my primary school playground in the 1970s, it described children being nasty to other children. Now bullying easily refers to adults undermining adults in the workplace, or online trolling, and has grown to go beyond intimidating behaviours to ones that exclude, such as shunning or 'ghosting'.

'Vertical creep' refers to the absorption of less severe phenomena, and resembles hyperbole (or exaggeration) of the type Furedi doesn't like, nor the US psychiatrist Allen Frances, who rails against the increase of psychiatric diagnostic terms.[5] So, using the example of bullying again, the term – in the workplace literature at least – now seems to include one-off acts or ones that weren't *intended* to be bullying, but the subjective experience of the victim is emphasised instead.

Haslam concedes such creep could be a good thing. It is surely good that we are alive to psychological harms and want to be thorough about including all potential targets of these. Without concept creep of trauma, we might have ignored the egregious effects of racial microaggressions, and without the creep of abuse to the financial realm, many domestic harms would be unrecognised and unsupported. Anxiety is also, appropriately, absorbing people's debilitating concerns about the safety of our planet and our future on it.

However, Haslam also has concerns that echo the Furedi and 'therapism' camps. He thinks that the loosening of the definitions of our harms runs the risk of entrenching a growing cultural cleave between 'victims' and 'perpetrators' or 'the harmed' and 'the harmers', or, what we see blowing up online all the time, the destructive fights between those clinging to being 'right' while insisting on others being 'wrong'.

I think Haslam is right to flag the point that it becomes easier to dig your heels in during a difference or conflict with the heft of a psychological (or pseudo-psychological) label. Statements that shut another person down, such as 'I have boundaries so I can't do x' or 'You are triggering me so I'm walking away', will inevitably favour the subjective experience of its speaker, making it difficult or impossible for another to challenge. If this opportunity for reciprocity and communication evaporates, a conversational cul-de-sac is its residue. Of course, both of these suggested statements can be true, but now we can be confused as to when they are or when they aren't, or when they are stated in error or as a deliberate means to avoid self-reflection.

The inherent opacity of psychological terms used out of their original contexts notably played out when the Hollywood actor Jonah Hill's ex-girlfriend Sarah Brady posted screenshots of some texts he sent to her in the summer of 2023.[6] Online opinion split between those who supported his use of words such as 'boundaries' and 'triggering' as appropriate (especially as they came from a man who would not be expected to show his vulnerability), while others thought he used them to assert power and control over Brady, above anything else.[7] Words that have no settled agreement among 'lay' users, such as 'gaslighting' or 'trauma', tend to reflect divisions and disagreements among researchers and clinicians too.

The momentum of today's increased interest in mental health and psychological functioning offers an opportunity for us all – including those who go to therapy – to think about the words we use more and reflect further on what we mean when we use them. Therapists have an opportunity to help clients do this, just as we should be making every effort to understand the meaning of all words we hear. This isn't so much about 'policing' words used but exploring as to whether they are used to capture the meaning intended by them – or indeed if words not used (like 'trauma') should be used too.

*This article has been edited and first appeared on Substack @juliabuenotherapist*

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**ABOUT THE AUTHOR**

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# Letters

## Your feedback on *Therapy Today* articles

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### Reclaiming a name

I want to thank the authors of two October 2025 articles in *Therapy Today*: Camilla Balshaw and Duni Vincent for 'Reclaiming a name' and Dwight Turner for 'Hearing, feeling, holding'. Both pieces resonated deeply with me and offered important reflections on identity, visibility and courage.

Balshaw and Vincent explore the significance of names in shaping identity – a theme that reminded me of my own experience with my name. When I first arrived in the UK I changed the pronunciation of my name. At the time it felt like a quiet way to fit in. Yet over time my Polish name disappeared. When I decided to reclaim it I noticed my own anxiety or frustration when saying my name because of the reactions I get: 'Sorry? I didn't hear that...' or 'Say it again. What is your name again? How do you pronounce it?'

Today I see both versions of my name as a symbol of my dual identity; a bridge between the person I was and the person I have become. The article reminded me that names are deeply entwined with belonging, self-expression and cultural history.

Meanwhile Dwight Turner offers a different but equally powerful reflection. As a woman of Polish ethnicity I often feel that my experiences are not significant enough to share. Turner's article felt like a call to acknowledge ethnic and racial invisibility and to embrace the courage to sit with our own judgments, biases and racial imprints. It was a reminder that, as counsellors, we must be willing to feel, hold and witness not only our clients' vulnerabilities but our own in the face of the system that we are living in. It made me think again about what 'whiteness' is, and even if I feel emerging shame and defensiveness, I broadened my perspective and opened the gateway


to look at it with humility. Turner's invitation to practise honesty and courage in facing our internal responses felt both challenging and liberating.

**Justyna Isobel Matejek MBACP (Accred), supervisor, counsellor, tutor and group facilitator**

### Rude awakenings

I want to thank Alix Fox for a really insightful analysis of a difficult subject area ('Rude awakenings', *Therapy Today*, November 2025). It is greatly appreciated as a professional who has previously been trained and involved in the Assessment, Intervention and Moving On (AIM) processes as a social worker involved in child protection.

I think there's something to understand about the economics here as well, and how this may further support the argument that therapist Gavin Conn referenced in the article: he puts forward that: 'lots [of people viewing child sexual abuse material (CSAM)] start viewing pornography in an unhappy place, or a stressed place, and that ends up driving them to a monstrous place.'

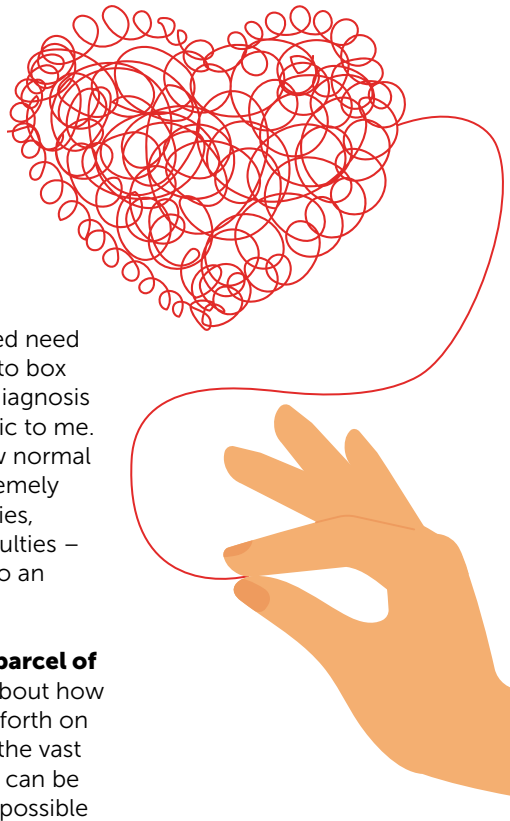
> "The article reminded me that names are deeply entwined with belonging, self-expression and cultural history"

Most social media promotion is driven by engagement, using metrics such as 'likes', views or comments. Industry reports emphasise that adult content platforms prioritise subscription-based and pay-per-view models because they provide steady revenue streams. Promoted content often aligns with categories that historically convert free users into paying customers rather than those with the highest free view counts. Studies on recommendation systems (for example, YouTube and TikTok) show that monetisation and engagement goals can create 'rabbit hole' effects, where progressively more extreme content is surfaced to maintain an individual's attention. While to the best of my knowledge adult platforms aren't widely studied in academia, it makes sense that similar economic and algorithmic principles would also apply.

This raises concerns not about the monetisation of CSAM itself but about how the way this industry is structured and monetised might incidentally drive people towards extreme content. This relates more broadly to trends that Fox points out, such as the normalisation of 'sexual choking'. For young people accessing pornographic material online, and increasingly living in this domain, their exposure to online content forms part of their sexual education, whether or not that was the intention. There's a systemic question here then about whether young people are increasingly, and incidentally, being funnelled towards extreme sexual content. It's not something researchers have clear answers on at present, but that in itself may be its own significant concern.

**James Mackenzie MBACP, social worker, psychodynamic counsellor and NHS child and adolescent counsellor**

# Cordelia Galgut



**Rigidity isn't helpful.** After living 70 years on this earth, I have to keep reminding myself to be open to new ways of thinking. It's so easy to become varying degrees of rigid without realising it. Not that I think there is anything wrong with being steadfastly committed to one approach or another, but understanding that it could be counterproductive, to varying degrees of unhelpful, seems crucial to me. It's often so much easier to stay stuck in a rut.

**Never underestimate the merits of therapist self-disclosure.** Over the years I have reflected on this huge area personally and professionally. I remember as a child being acutely aware of the strategies we often employ as human beings in order to try to lessen overwhelming feelings and conform to the norm. I recall watching people contorting themselves not to say how they really felt. It was such a liberation when, as an adult, I started to realise it wasn't a crime to admit, for example, that I was scared, upset, terrified even. However, I still butt up against people who don't like me being too truthful when I name my own very extreme emotions that endure. Nonetheless I've learned that my clients tend to like my disclosures and say that they help them validate their own intense feelings. I'd go so far as to say that my willingness to be authentic in many areas has been a lifesaver for some of my clients.

**Simplifying can be counterproductive.** I have learned to resist the temptation to be over-formulaic or to simplify what's not simple. There aren't always simple ways of understanding or coping with complex experiences. In my clinical experience, the more we validate how nuanced and enduring many of life's more extreme challenges are, the happier and more centred my clients become.

**I worry about the rise in diagnoses.** Since I started working as a therapist decades ago, focus on the *Diagnostic and Statistical Manual of Mental Disorders* has grown enormously. The increased need to box people off, or for people to box themselves off, also calling the diagnosis a disorder, does not seem realistic to me. Arriving at an acceptance of how normal it is for human beings to be extremely overwhelmed by life's complexities, conflicts and the inevitable difficulties – often unbearable ones – is key to an ongoingly contented life.

**Extreme feelings are part and parcel of being human.** We seldom talk about how common it is to move back and forth on a mental health continuum. For the vast majority of us, our presentations can be extreme when confronted by impossible situations, such as the death of a partner or a child, or even less extreme challenges. Certain times of life are likely to catapult us into the hugely emotionally disrupted category – that is normal, as opposed to diagnosable. Obviously there are some for whom movement away from extremity is impossible, but in my experience mental health is more fluid for most of us. We are all under societal pressure to conform to some perceived norm of mental health.

**I'm wary of many research findings.** Perhaps taboo, having conducted a fair amount of formal research myself, I know how open to being flawed and inaccurate data can be. We can be over-reliant on research and its value, and susceptible to pressure to justify our value and existence, based on how much research we conduct. However, I do think certain kinds of research approaches are more foolproof than others. Who funds and conducts the research are key factors in this.


## ABOUT THE AUTHOR

**Dr Cordelia Galgut MBACP (Snr Accred), HCPC** is a counselling psychologist and psychotherapist with decades of experience, specialising in cancer, chronic illness, menopause, sexuality and the impact of trauma.
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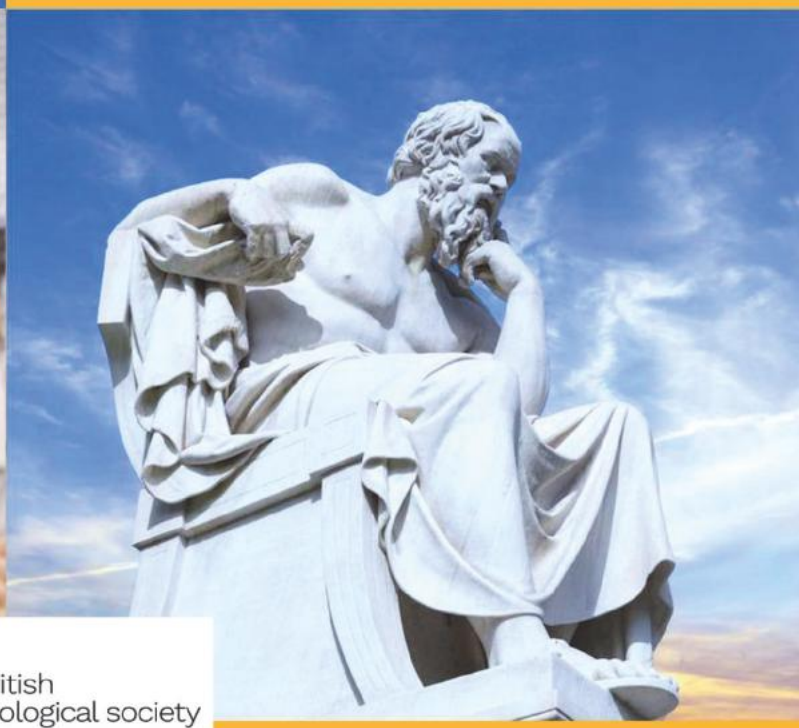
*'There aren't always simple ways of understanding or coping with complex experiences. The more we validate how nuanced life's challenges are, the happier my clients become'*



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